HOMETOWN HEALTHCARE

1820 43rd Ave
Suite B
Vero Beach, Florida 32960

Family Authorization to release Protected Health Information

By authorizing the listed people below, they will have access to any and all of my health information, up to and including HIV, drug, alcohol, and psychiatric records. Hometown Healthcare affiliates are permitted to share my medical information with them, including test results, appointment reminders and information disclosed during office visits.

Patient: _____ DOB: _____

Persons (Other than physicians) authorized to receive my medical information:

1. Name: _____

Relationship: _____

Phone Number: _____

Okay to leave messages? ____Yes OR _____NO

1. Name: _____

Relationship: _____

Phone Number: _____

Okay to leave messages? ____Yes OR _____NO

1. Name: _____

Relationship: _____

Phone Number: _____

Okay to leave messages? ____Yes OR _____NO

I understand and direct that this authorization will remain in effect until it is revoked by me (the patient) in writing.

HIPAA: This organization complies with all HIPPA and other federal privacy regulations. A notice of privacy policies is available upon request. I acknowledge by signature below that I have been made aware of my right to review or obtain a copy of the policies.

NOTICE OF HEALTHCARE INFORMATION: All patient records remain the property of this practice. Records are centralized and may be accessed by medical providers or employees as necessary function of their role within the organization. The organization does not release patients' information unless necessary for the purpose of medical treatment, obtaining payment or supporting the day-to-day health care operations of the practice. Patient signature below provides your consent to use and disclose my health information in accordance with the above statement.

Patient Signature: _____ Today's Date: _____