

PROTECTED HEALTH INFORMATION RELEASE

Please check all that apply and list name(s) of spouse, child(ren) and others involved in care as applicable.

- You have permission to leave information on my answering machine regarding my medical care and test results.
- You have my permission to speak with my spouse about my medical care.
- You have my permission to talk with my children or other family members involved with my medical care.
- Other, please describe _____

Name: _____	Relationship: _____	Contact #: _____
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Name: _____	Relationship: _____	Contact #: _____
Name: _____	Relationship: _____	Contact #: _____
Name: _____	Relationship: _____	Contact #: _____

Upon request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____