Authorization Form to Release Protected Health Information (PHI) To Spouse / **Family Member/ Signifigant other**

This Authorization grants permission to my Spouse / Significant Other / Party Named Below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications; be made aware of my diagnosis, prognosis, and treatment plans; and have access to my financial health information.

I hereby authorize Northwest Preventive and Primary Care to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to my spouse / significant other, or the party named below, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME: _____

Date of Birth: _____

Name of Spouse , Significant Other, <u>Guardian or Family Member</u> : _____

Relationship to Patient: _____

Address: _____

Phone: _____

If address or phone number is different from Patient's, please provide information:

_____

<u>The patient must read and initial the following statements:</u>

1. I understand that this authorization will (Please check one)

   o Expire 1 year from the date signed by the patient

   o Be effective for the lifetime of the patient unless revoked (see # 2 below)

   Patient's Initials: _____

2. I understand that I may revoke this authorization at any time by notifying Northwest Preventive and Primary Care in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Northwest Preventive and Primary Care prior to their receipt of the revocation.

   Patient's Initials: _____

3. I understand that my treatment cannot be conditioned on whether I sign this authorization.

Patient's Initials: _____

(Form must be completed before signing or will not be valid)

Patient's Signature: _____

Date: _____

* * YOU MAY REFUSE TO SIGN THIS AUTHORIZATION * *