PROTECTED HEALTH INFORMATION
AUHORIZED PERSON(S)

Please **print** information below:

I _____, hereby authorize release of my **minor child's** Protected Health Information for Verbal Discussion only for their care and treatment to the person(s) specified below (45CFR, 164.502(F) & 164.502(G):

I _____, hereby authorize release of **my** Protected Health Information for Verbal Discussion only for my care and treatment to the person (s) below (45CFR, 164.502(F) &164.502(G) :

Patients Name: _____Date of Birth: _____

Authorized family member or person to receive information for the above names patient's care:

_____ _____ _____
Name of Central Contact (other than patient) Relationship to Patient Phone

Others authorized to receive my verbal information (please list names and relationship):

_____ _____ _____
Print Name Relationship to Patient Phone

_____ _____ _____
Print Name Relationship to Patient Phone

Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper copies of your medical records. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations.

NOTE: By signing and dating this Protected Health Information Authorized person (s) form, I revoke all previously signed Protected Health Information Authorized Person(s) form.

_____ _____
Patient Signature Date

_____ _____
Personal Representative Relationship to Patient

NOTE: Except to the extent that action has already been taken in reliance on this Protected Health Information Authorized Person(s), at any time I can revoke this Protected Health Information Authorized Person(s) by submitting a new Protected Health Information Authorized Person(s) form or by written notice to the Family Health Center where my medical records are kept.