PROTECTED HEALTH INFORMATION AUTHORIZED PERSON(S)

Please print below information

I,_____, hereby authorize release of my Protected Health Information for **verbal discussion only** of my care and treatment to the person(s) specified below.

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

_____	_____	(_____)_____
PRINT NAME	RELATIONSHIP	PHONE
_____	_____	(_____)_____
PRINT NAME	RELATIONSHIP	PHONE
_____	_____	(_____)_____
PRINT NAME	RELATIONSHIP	PHONE
_____	_____	(_____)_____
PRINT NAME	RELATIONSHIP	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 or electronic access of your medical record. 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 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.

- **Leave message on answering machine or voice mail? YES _____ NO _____**

(Example: We may leave message reminders, scheduling changes, or notices that lab results are in on your answering machine.)

- **Leave message for patient to return call? YES _____ NO _____**

(Example: We may leave a message regarding appointment reminders, scheduling changes, or notices that lab results are in with an individual who answers the phone.)

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

Patient Signature _____ Date _____

Personal Representative _____ Relationship to Patient _____

PATIENT NAME:_____
DATE OF BIRTH:_____