

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members, such as spouses, parents, significant others, or children, to call and request the results of labs, procedures, tests, and appointments. Under the requirements for HIPAA, we are not allowed to give this information to anyone without our patient's authorization. If you wish to have your medical information, any diagnostic test/results, and/or appointment information, and other related protected health information released to family members, you must complete this form. This authorization is voluntary and your treatment is not conditioned on your decision to grant us this authorization.

You have the right to revoke this authorization, in writing, except where we have already made disclosures in reliance on your prior authorization.

I hereby authorize ConvenientMD Primary Care to release my medical records and any information (including protected health information) requested to the following individuals.

_____ **Relation to Patient:** _____ **Phone:** _____

_____ **Relation to Patient:** _____ **Phone:** _____

_____ **Relation to Patient:** _____ **Phone:** _____

_____ **Relation to Patient:** _____ **Phone:** _____

_____ **Relation to Patient:** _____ **Phone:** _____

Authorization Regarding Messages (Please check all that apply)

_____ **I authorize you to leave a detailed message on my home or cell phone number regarding appointments**

_____ **I authorize you to leave a detailed message on my home or cell phone number regarding medical treatment, care, test results or financial information**

_____ **I authorize you to leave a message with authorized individuals on this form**

This authorization will auto renew annually unless revoked by you.

Patient Name (PLEASE PRINT)

Date

Patient Signature