*PERMISSION TO COMMUNICATE WITH FAMILY MEMBERS AND/OR OTHERS *

As required by the Health Insurance Portability and Accountability Act of 1996 (HIP AA), health care providers are prohibited from releasing or discussing any personal health information to anyone without appropriate permission. Therefore, we need your written authorization if you would like us to communicate with family members or others involved in your care (or your child's care, if applicable). Please let us know with whom we may communicate regarding any aspects of your health care (or that of your child, if applicable).

I, _____ authorize Suncoast Premier Medical to release or discuss information about my health with:

Relationship: (check one) (and the person must be at least 18 years old)

Spouse / Partner Name: _____ DOB: ___/___/___ Tele Number _____

Mother/Father Name: _____ DOB: ___/___/___ Tele Number _____

Son/Daughter Name: _____ DOB: ___/___/____ Tele Number _____

Social or DCF Worker Name: _____ DOB: ___/___/___ Tele Number _____

In-law Name: _____ DOB ___/___/___ Tele Number _____

Other: _____

Relationship to Patient: _____

Date of Birth: _____

Tele Number: _____

INDIVIDUAL'S SIGNATURE_____ Date of Birth: _____

Last Four Social Security Number _____Date: _____