AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient Name: _____ **Date of Birth:** _____

Many of our patients allow family members such as their spouse, parents or others to request medical or billing information. In accordance with Federal government privacy rules implemented through the Healthcare Portability and Accountability Act of 1995 (HIPAA) we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members or other individuals indicated below.

I authorize Glen Rose Medical Center to release my medical and/or billing information to the following individual(s):

1. _____ Relationship to Patient: _____

2. _____ Relationship to Patient: _____

3. _____ Relationship to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipients is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

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

_____ _____

Patient's Signature Date