

Authorization to release health information

Patient Name: _____

Date of Birth: _____

We require your written authorization prior to sending any protected health information per HIPAA regulations. Please list below any names and addresses of persons to which you wish your medical records be sent.

I authorize Jefferson Street Family Practice to release my protected health information to the following person(s): (other doctors/attorneys/employer). I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to this office.

Patient Signature: _____ Date: _____

Please initial if you authorize us to speak to the following:

Spouse_____ Mother _____ Father_____ Daughter_____ Son_____

Please write the names and relationship of any other family or friends you authorize us to speak with:

I authorize the release of my protected health information to Jefferson Street Family Practice from any physician, hospital or clinic to facilitate my treatment by the physicians at Jefferson Street Family Practice.

Patient Signature: _____ Date: _____