Authorization to Share Health Information with Family Members or Friends

(This form does NOT authorize release of copies of the medical chart)

Patient Full Name: _____ Date of Birth: _____/_____/_____
(First) (Middle) (Last)

Many of our patients allow family members such as their parent(s), grandparents, guardians or others to call and discuss their medical/billing information, request prescriptions; vaccine information, medical records and results of tests also pick up forms, etc. Under the requirements of HIPAA we are not permitted to release this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members or friends, you must sign this form.

☐ I decline to have my medical information discussed with family and friends.

☐ I give permission to Keystone Health to discuss my health information listed above to the following individuals:

Name _____Relationship_____

Name _____Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

- I understand I must sign a separate authorization form releasing copies of my medical record to another individual.
- I understand I have the right to revoke my permission at any time except where Keystone Health has already made disclosures in reliance upon this requests. I understand this this permission remains in effect until the time I revoke in writing.

_____ _____
Signature of Patient/Person Representative Date

_____
Personal Representative/ Relationship to patient

_____
Staff Member Signature