Authorization for Release of Information – Compound Release

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

Prime Care Family Practice is authorized to release protected health information about the above-named patient in the following manner and to identified persons.

Entity to Receive Information Check each person/entity that you approve to receive Information.	**Description of information to be released** Check each that can be given to person/entity on the left in the same section.
☐ **Voice Mail**	☐ **Financial** ☐ **Medical** ☐ **Other** _____
☐ **Spouse (provide name and phone number)** _____	☐ **Financial** ☐ **Medical**
☐ **Parent (provide name and phone number)** _____	☐ **Financial** ☐ **Medical**
☐ **Other (provide name and phone number)** _____	☐ **Financial** ☐ **Medical**

☐ **Receive detailed lab results via automated phone message. The number to contact is:** _____

Consent to Communicate Protected Health Information: I consent to have my medical information shared with a national database so that my other healthcare providers may access it:

◯ **Consent** ◯ **Do Not Consent**

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ **Date** _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)