

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.

Signature of Patient or Personal Representative

Date

Signature of Patient or Personal Representative

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