Inspiration Health Services

# Authorization to Release Protected Health Information to Family Members/Friend

Patient Name: _____Date of Birth: _____

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; medical records, test results, 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 fill out the bottom portion and sign the form.

**By signing this authorization, I allow Inspiration Health Services to discuss with the person(s) named below my personal health information which may include, but not limited to laboratory, test results, diagnosis, treatment plan, and billing status. This may be done in person or by telephone.**

**By signing this authorization, I understand the following:**

This applies to services being rendered to me by any of the providers who practice under Inspiration Health Services.

Once this information is released to the designated family member, friend, or other person named below, the released information may no longer be protected by the federal privacy regulations.

**This authorization is voluntary.**

I may withdraw this authorization at any time by notifying Inspiration Health Services in writing. If I do withdraw the authorization, it will not have any effect on actions taken by Inspiration Health Services prior to receiving the written request.

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|---|---|---|
| 1. Name | Phone: | Relationship to patient: |
| 2. Name | Phone: | Relationship to patient: |
| 3. Name | Phone: | Relationship to patient: |

Patient Signature: _____Date: _____