

Authorization to Release Information to Family/Friend

Patient Name: _____ Date of Birth: _____

Name of Person: _____

Relationship: _____ *Contact Number:* _____

Name of Person: _____

Relationship: _____ *Contact Number:* _____

Name of Person: _____

Relationship: _____ *Contact Number:* _____

Check mark if Power of Attorney paperwork on file

I give my permission for East Lincoln Family Health Professionals, P.C. to exchange/release my protected health information upon request of named above. Including, but not limited to, diagnosis, treatment, appointments, results, medications, billing (unless specified otherwise):

This Authorization will be effective until revoked. You may revoke authorization anytime by notifying in writing to our office.

Signature of Patient/Legal Guardian

Date