



HIPPA Consent for Patient Information Release

Patient Name: _____
Date of Birth: _____ SS#: _____

I Authorize Memorial Medical Group to release my personal health information to family members or others involved in my care or assisting me with financial payment arrangements.

Name: _____ Relationship: _____
Phone # or contact information: _____

Name: _____ Relationship: _____
Phone # or contact information: _____

Name: _____ Relationship: _____
Phone # or contact information: _____

Privacy Information Please circle **YES** or **NO** for the following statements. By circling **YES** for the following statements this office will leave voicemail or answering machine messages at you home, work or emergency contact on file that may include your protected health information and that may be overheard by others not involved in your care.

<u>Place</u>	<u>Call back / Message</u>	<u>Detailed Message</u>
Home	Yes / No	Yes / No
Work	Yes / No	Yes / No
Emergency Contact	Yes / No	Yes / No

Patient Signature _____ Date _____

Witness _____ Date _____

This form will remain in effect for One Year from the date of signature. Any changes to this form must be submitted on a new form by the patient and witnessed.