Midland Family Physicians, P.C.

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Authorization to Release Information to Family/Friend

Patient Name ______________________ Date of Birth ______________

Midland Family Physicians, P.C. may leave a detailed message at the numbers listed below

Preferred contact number: ______________________ Other: ______________

I authorize my health care providers to disclose and release my protected health information described below to:

Name ______________ Phone Number ______________ Relationship ______________

Name ______________ Phone Number ______________ Relationship ______________

Name ______________ Phone Number ______________ Relationship ______________

Specific type of information for disclosure:

____ My entire medical record (including mental health records, communicable diseases including HIV/AIDS, alcohol/drug abuse treatment, etc).

____ Other ______________________________________

I authorize my provider to disclose to those listed above in the following format(s):

___Verbal

___Paper copy

This authorization goes into effect immediately. I understand that I may revoke this authorization at any time in writing. Otherwise, this authorization will remain in place until a new form is completed.

I understand that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this authorization.

I understand that any disclosure to an individual made from this authorization carries with it the potential for that individual to disclose the information and that once a disclosure is made under this authorization that it is no longer protected by federal and state confidentiality laws.

By signing this form, I confirm that I understand the information and any questions I have were answered.

Patient or Legal Representative Signature ______________________ Date ______________

Witness (Staff) Signature ______________________ Date ______________