Authorization for Release of Information to Family Members

Patient's Name: _____ Birth Date: _____

Many of our patients allow family members such as their spouse, parent, adult children or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize **Bainbridge Vision** to release my medical and/or billing information to the following individual(s):

Full Name:_____ Relation to Patient_____

Full Name:_____ Relation to Patient_____

Full Name:_____ Relation to Patient_____

Full Name:_____ Relation to Patient_____

Full Name: _____Relation to Patient_____

Patient Information

I understand that I may cancel this consent at any time (by writing to Bainbridge Vision Medical Records), but that canceling it will not affect any information that has already been released.

I understand that information disclosed to any above recipients is no longer protected by federal or state law and may be subject to disclosure by the above recipient.

Relationship to minor patient (If parent or legal guardian): _____
If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney).

Signature: _____ Date: _____
***This authorization for release of information to family members expires 1 year from signature date.**

Signature: _____Date Renewed: _____
***This authorization for release of information to family members expires 1 year from signature date.**

Signature: _____Date Renewed: _____
***This authorization for release of information to family members expires 1 year from signature date.**