Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth _____

Many of our patients allow family members such as their spouse, parents 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 information, any diagnostic test results and/or financial information released to any family members, you must sign this form. Signing this form will allow permission for us to give information to the family members indicated below only. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Renaissance Health and Surgical Associates to release my records and any information requested to the following individual(s):

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

4. _____ Relation to Patient: _____

Authorization Regarding Messages
(please check all that apply)

_____ I authorize you to leave a detailed message on my home or cell number regarding appointments.

_____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

____ I authorize you to leave a message with anyone who answers the phone.

____ Messages may only be left with _____.

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

_____ _____
Patient Name (Please Print) Date

_____
Patient Signature

Revised 3/24/2022