**Release of Medical Information**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Amethyst Medical Group providers and staff to release my protected health information with:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Individual | Relationship | Phone Number | Instructions (i.e: may pickup meds, may disclose test results, may discuss care, all access, etc) |
|  |  |  |  |
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|  |  |  |  |

The Physician/Staff has my permission to: (Please check all boxes that apply)

\_\_\_ Leave message at home with my spouse or Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Leave message on my cell phone

\_\_\_Leave message at work

\_\_\_Leave message on voicemail or an answering machine

This authorization shall be in force and in effect from the date of signature until \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing, at anytime.

By signing this consent form, I give permission to the person(s) listed above to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPPA compliant authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date of Birth Date