



PREMIER FAMILY PHYSICIANS

PATIENTS AGE 18 OR OLDER

CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

Patients Name: _____ Birthdate: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for _____ and his/her staff to disclose my personal medical information to the following individual(s):

Name: _____ Relationship to Patient: _____ Phone# _____

Name: _____ Relationship to Patient: _____ Phone# _____

Name: _____ Relationship to Patient: _____ Phone# _____

Conditions for Disclosure (Check the item(s) that apply):

- Premier Family Physicians may disclose my medical information to the individual(s) above when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

Please note:

Premier Family Physicians will not disclose confidential information without a specific release. See release below:

I authorize the release of information relating to:

- Alcohol / Drug Abuse Evaluation/Treatment
- HIV / AIDs / STD Evaluation/Treatment
- Psychiatric / Mental Health Evaluation/Treatment
- Pregnancy Evaluation/Treatment

Authorization:

- I authorize Premier Family Physicians to release the information marked above.
- I understand that when the health information is released, the information could be redisclosed by the recipient and may no longer be protected by federal or state privacy laws.
- I understand that my health care and payment for health care will not be affected if I do not sign this form.

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____

Date of Signature: _____