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 Physicians may disclose my medical information to individual(s) above when I am not physically present, including disclosures by telephone, fax, 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 this consent may be revoked by me at any time by written notice to the practice.

Patient Signature/Personal Representative: _____

Date of Signature: _____

Description of Representative's Authority: _____