PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION

PRINT PATIENT'S FULL NAME: _____

PATIENT'S DATE OF BIRTH: _____ **TELEPHONE:** _____

PATIENT'S ADDRESS: _____

I give Family First Health permission to discuss protected health information and to release test results to the following person(s):

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

I give Family First Health permission to leave any protected health information on an answering machine or voicemail. ___Yes ___No Telephone Number: _____

By signing this form I give Family First Health permission to send your medical information to the address provided.

Indicate your relationship to the patient: ____Patient _____Patient Representative

_____

Print Name (if you are not the patient)

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRSENTATIVE **TODAY'S DATE**

This form is good for 1 year unless you tell us otherwise. If you want to, choose another date:

_____