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 my 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 REPRESENTATIVE **TODAY'S DATE**

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