PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Falls Medical Specialists LLC to release my records and any information requested to the following individuals.

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

3. _____ Relation to Patient:_____

4. _____ Relation to Patient:_____

Authorization Regarding Messages (please check all that apply)

☐ I authorize you to leave a detailed message on my home or cell number regarding appointments

☐ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

☐ I authorize the use of text messaging from my doctor and the office on the doctors behalf

☐ I authorize you to leave a message with anyone who answers the phone

☐ Messages may only be left with _____

_____

Patient Name (PLEASE PRINT)

_____ _____

Patient Signature Date