



## Authorization for Communication of Protected Health Information to Family and Friends

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I, \_\_\_\_\_, authorize AllCare Medical Group to discuss/share my protected health information with the following individual(s):

_____ Name	_____ Relationship	_____ Phone Number
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_____ Name	_____ Relationship	_____ Phone Number
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_____ Name	_____ Relationship	_____ Phone Number
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### Type of information to be shared or disclosed:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Appointment Information   | <input type="checkbox"/> Medical Information | <input type="checkbox"/> Prescription Information |
| <input type="checkbox"/> Mental Health Information | <input type="checkbox"/> Lab/Imaging Results | <input type="checkbox"/> Any Information          |

☐ I do not authorize AllCare Medical Group to share my protected health information with any individuals.

I authorize AllCare Medical Group to leave detailed messages about my medical and health information on the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Cell Phone Voicemail | <input type="checkbox"/> Home Phone Voicemail |
|---|---|

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(This authorization shall remain in effect until revoked by the patient or for 1 year. You may request a new form at any time. Submitting a new form will replace the existing form.)*