WELLSPRING
FAMILY PRACTICE

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 WellSpring to discuss/share my protected health information with the following individual(s):

Name	Relationship	Phone Number

Type of information to be shared or disclosed:

- ☐ Appointment Information
- ☐ Medical Information
- ☐ Prescription Information
- ☐ Mental Health Information
- ☐ Lab/Imaging Results
- ☐ Any Information

☐ **I do not authorize** WellSpring to share my protected health information with any individuals.

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

- ☐ Cell Phone Voicemail
- ☐ 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.)

A part of allcare Medical Group

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