Hunterdon Health

Permission to Share Medical Information

AUTHORIZATION TO RELEASE MEDICAL AND/OR PAYMENT INFORMATION TO DESIGNATED RELATIVE, CLOSE FRIENDS AND OTHER CAREGIVERS

I agree that "The Practice" may disclose my health information to a family member, close friend, or other such person who is involved with my healthcare or payment relating to my healthcare. "The Practice" will disclose only information that is directly relevant to the person's involvement with my healthcare or payment related to my healthcare.

I designate the person(s) listed below as person(s) involved with my healthcare or payment to my healthcare for the limited disclosure described above. I understand that I am not required to list anyone. I also understand that I may change or remove this authority at any time in writing.

_____

Patient's Name *Patient's Date of Birth*

_____

Practice Name

1. _____
   Name *Phone* *Relationship to Patient*

   ___OK to leave a voicemail message on Cell#_____ Home#_____
   Initial *Initial* *Initial*

2. _____
   Name *Phone* *Relationship to Patient*

   ___OK to leave a voicemail message on Cell#_____ Home#_____
   Initial *Initial* *Initial*

_____ _____

Patient's Signature *Patient's Name (print)*

_____

Date