CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION (HIPAA)
Family Physicians of Greeley, PLLP

Name: _____ **Date of Birth:** _____
Name of Patient or Guardian

Release of Information

☐ I authorize Family Physicians of Greeley, its employees and agents to disclose my health information, including my visit records, diagnoses, treatments and test results, to the person(s) identified below. I understand that any personal health information released to the person(s) identified may be subject to re-disclosure by such person and may no longer be protected by applicable federal and state privacy laws.

This information may be released to:

☐ Spouse: _____

☐ Child[ren]: _____

☐ Other: _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

I understand that I have a right to revoke this authorization by providing written notice to Family Physicians of Greeley. However, this authorization may not be revoked if Family Physicians of Greeley, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for healthcare services.

Messages

Please call: ☐ my home: _____ ☐ my work: _____

☐ my cell phone: _____ ☐ other: _____

If unable to reach me: ☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ other: _____

The best time to reach me is (*days*) _____, between (*time*)_____

Signed: _____ Date: _____

Witness: _____ Date: _____

12/1/15