

**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 medical information and financial information. Under the requirements for HIPAA (Health Insurance Portability and Accountability Act) we are not allowed to give this information to anyone without the patient’s consent. If you wish to have your medical information, and/or financial(billing) 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 according to your prior consent.

**I authorize Lake City Physical Therapy to release my records and any information requested to the following individuals:**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

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