PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members and Trusted Individuals

Patient Legal Name: **Patient Date of Birth:**

Many of our patients allow family members such as their spouse, significant other, parents, children, or other trusted individuals to call and request the results of tests, procedures, and financial information. Under HIPAA regulations, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, test results, and/or financial information released to any family members or other trusted individuals, you must sign and return this form to the clinic.

Financial information includes payment methods (account type and last 4 digits of account number), invoices, clinic membership status, and insurance information.

You have the right to revoke this consent, in writing, except where we have already made disclosures in accordance with your prior consent.

I authorize Still Point Direct Primary Care and any of its agents to release protected health information for the patient named at the top of this document, including medical records and financial information, to the following individuals:

1. _____ **Relation to Patient:** _____

2. _____ **Relation to Patient:** _____

3. _____ **Relation to Patient:** _____

4. _____ **Relation to Patient:** _____

_____ _____

Printed Name of Patient or Legally Authorized Representative Date

_____

Signature of Patient or Legally Authorized Representative