Authorization for Release of Information to Family and/or Friends

First Name Last Name

Name of Patient(s):_____ Date(s) of Birth: _____

Please circle who we are able to give information to: spouse, step-mother/father, grandparents, biological father/mother, nanny, other (indicate "other") _____

Please print the name of the person you have authorized for us to release the information to, as indicated above

_____, _____, _____

Initial each that you authorize

_____ Leave information on the voice mail

_____ If they call, we are able to discuss over the phone

_____ Electronic mail

Description of information to be released

_____ Financial information

_____ Family billing information

_____ Information results from test and x-rays

_____ Medical information as follows: _____

Rights of the Patient

I understand that I have the rights to revoke this authorization at any time and that I have the right to inspect or copy the protect health information to be disclosed as described in this document by sending a written notification to Dr. Kisha S. Mitchell I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and in effect until revoked by the patient or representative signing the authorization.

_____ _____

Signature of Parent, Legal Guardian, or Personal Representative Date

_____

Description of Personal Representative's Authority (attach necessary documentation)