Silver Sage
CENTER FOR FAMILY MEDICINE

Authorization to release Personal Health Information and HIPAA Privacy Acknowledgement

Patient Name: _____DOB:_____Date: _____

Please fill in the following:

Leave a message on your home answering machine/voicemail? ☐ Yes or ☐ No
Leave a message with a family member/member of household? ☐ Yes or ☐ No
Leave a message at your place of employment? ☐ Yes or ☐ No

Discuss your medical condition with a family member/member of your household/friend/other? ☐ Yes or ☐ No
If yes, please list names and relationship: _____

_____

Release any of your medical information (office notes, lab reports, etc.) to a family member/member of your household/friend/other? ☐ Yes or ☐ No
If yes, please list name and relationship: _____

_____

Discuss your medical billing or insurance information with a family member/member of your household/friend/other? ☐ Yes or ☐ No
If yes, please list names and relationship: _____

_____

Are any of those people your Power of Attorney? ☐ Yes or ☐ No If yes, who _____

I authorize the release of my medical records to other physicians/healthcare providers? ☐ Yes or ☐ No
Please List: _____

I hereby authorize Silver Sage Center for Family Medicine to obtain or release all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment or from other health care providers, laboratories, radiology facilities or other institutions. Furthermore, I authorize the release of information to those family/friends listed above. This authorization remains in effect until revoked.
I have reviewed and confirm the above information is true and correct and provide my consent regarding all above stated authorizations. I acknowledge that I have read and understand and have been offered a copy of the Silver Sage Center of Family Medicine private policy form. I understand that Silver Sage Center for Family Medicine complies with all applicable Federal Civil Rights laws and does not discriminate based on race, color, national origin, age, disability, or gender.

_____ _____
Signature of patient/guardian Signature of witness (staff member)

_____ _____
Name of patient/Guardian Date Name of witness Date