SIMEDHealth

HIPAA Release

PATIENT'S NAME: _____ DATE OF BIRTH: _____

As part of your continuing care, you may wish for a friend or family member to have access to your protected health information (PHI). This form allows your healthcare team to share only the information you have authorized to the people listed below. This authorization will remain in effect until you revoke it in writing. For information on our HIPAA policies, please see a member of your healthcare team.

I am authorizing the person(s) listed below to have access to my protected health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I am authorizing the person(s) listed above to have access to the information I have selected below (check one of the 3 boxes):

☐ All my health information **including** extremely confidential materials such as: HIV/AIDS, Alcohol/Drug Abuse, Psychiatric/Psychotherapeutic, Sexually Transmitted Disease	
☐ All my health information **excluding** extremely confidential materials such as: HIV/AIDS, Alcohol/Drug Abuse, Psychiatric/Psychotherapeutic, Sexually Transmitted Disease	
☐ All my health information **except**:	

I wish for my SIMEDHealth healthcare team to contact me:

Please Call:	Phone Number:	Best Time To Reach Me:
☐ My home phone	( )	
☐ My cell phone:	( )	
☐ My work phone:	( )	

If unable to reach me:

☐ You may leave a detailed message ☐ You may leave a message asking me to return your call

☐ Other instructions: _____

_____ _____

Signature of Patient / Guardian Date