# Robeson Family Practice Associates, P. A.

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## AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Patients Name:____________________________________________
Patients Address:__________________________________________
Patients DOB:_____________________________________________

Many of our patients allow family members such as their spouse, parents or others to call and request medical (test results, discussion about medical conditions, medications, and treatment) or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow Robeson Family Practice to release any other information to these family members. You have the right to revoke this consent in writing. I authorize/allow Robeson Family Practice to release my medical and/or billing information to the following individual(s):

1. ______________________________ Relation to Patient:________________________
2. ______________________________ Relation to Patient:________________________
3. ______________________________ Relation to Patient:________________________

Patients Full Name (Printed):______________________________________

Patients Signature:__________________________ Date:__________________________

## AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS:

Occasionally, it is necessary for the staff of Robeson Family Practice to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of Robeson Family Practice discuss your medical condition without your consent. The purpose of this consent is to speak with members of your household. You have the right to revoke this consent in writing.

Patients Full Name (Printed):______________________________________

Patients Signature:__________________________ Date:__________________________

Revised on 11/20/2014