AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA 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 Integrity Health and Wellness to release any other information to these family members.

YOU HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING.

I authorize Integrity Health and Wellness to release my medical/billing information to the following individual(s):

Individual (1): _____

Relationship to Patient: _____

Individual (2): _____

Relationship to Patient: _____

Patient Name: _____

Patient Signature: _____

Date: _____