HIPAA Consent for Patient Information Release

Patient Name: ____

Date of Birth:_______________________ SS#:____________________________

I Authorize Beacon Medical Group to release my personal health information to family members or others involved in my care or assisting me with financial payment arrangements.

Name: ___________________________________ Relationship:________________

Phone # or contact information: ____

Name: ___________________________________ Relationship:________________

Phone # or contact information: ____

Name: ___________________________________ Relationship:________________

Phone # or contact information: ____

Privacy Information Please circle **YES** or **NO** for the following statements. By circling **YES** for the following statements this office will leave voicemail or answering machine messages at your home, work or emergency contact on file that may include your protected health information and that may be overheard by others not involved in your care.

Place	**Call back / Message**	**Detailed Message**
Home	Yes / No	Yes / No
Work	Yes / No	Yes / No
Emergency Contact	Yes / No	Yes / No

Patient Signature____Date___________

Witness____ Date___________

This form will remain in effect for One Year from the date of signature. Any changes to this form must be submitted on a new form by the patient and witnessed.