{PATIENT LABEL HERE}

FAMILY HealthCare

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name:_____ DOB:_____

I hereby give permission to Family HealthCare to verbally discuss and/or leave messages about my Protected Health Information (PHI) indicated on this authorization form. I am comfortable with Family Healthcare leaving general messages at these telephone numbers, patient portal and/or by text message (SMS).

PHI that may be discussed and/or messages left may include but not limited to:

- Appointment reminders (provider name, location, time, and date)
- Test and procedure general information
- Medication and Prescriptions
- Billing or payment information
- Referral information
- Other general health information

Marking below indicates authorization or decline:

Home Number	( ) Yes	( ) No
Cell Number	( ) Yes	( ) No
Work Number	( ) Yes	( ) No

Family Healthcare is authorized to discuss my care with:

Name:_____ DOB: _____ Relationship: _____

Name:_____ DOB: _____ Relationship: _____

Name:_____ DOB: _____ Relationship: _____

I understand that this authorization will remain in effect for one (1) year of signature date.

PLEASE NOTE: This release of information **does not** include written record requests to/from other medical offices, requests by insurance companies or other outside agencies. Specific releases will need to be obtained by the patient for these purposes.

Patient or Legal Guardian Signature: _____Date:_____

Legal Guardian Printed Name (if not patient): _____

{PATIENT LABEL HERE}

FAMILY HealthCare

AUTHORIZATION FOR MEDICAL /DENTAL CARE TO MINORS or ADULTS WITH DISABILITIES

For families who are ongoing patients of Family HealthCare, it may be more convenient to have prior authorization for medical/dental care delivered to minors/adults with disabilities if for some reason the parent/guardian is unable to be present. Please review the following authorization for treatment and complete the information if you want to pre-authorize treatment. Authorized person(s) MUST be 18 years of age or older.

AUTHORIZATION

Are you the legal guardian(s)? Yes_____ No_____ *(If no you cannot complete this form)*

☐ **I do NOT authorize Family Healthcare and its personnel to provide any medical /dental services to my minor without my presence except for in a life -threatening circumstance**

☐ **I authorize Family Healthcare and its personnel to deliver medical/dental care to my minor/adult listed below for whom we are the legally responsible party:**

Name of Minor/Adult with Disability: _____

Date of Birth: _____ Social Security Number: _____

Person(s) authorized to accompany minor/adult to clinic if legal guardian is unavailable:

Name:_____ Relationship to child/family:_____

Name:_____ Relationship to child/family:_____

Name:_____ Relationship to child/family:_____

PARENT / GUARDIAN SIGNATURE

I understand that I am giving permission to Family HealthCare to treat the above-named minor/adult with disability in the event that he/she presents to the clinic with one of the authorized individuals listed above, and that permission is granted to forward pertinent medical or other information from this visit to the insurance company if applicable.

I further understand that parent/guardian must be present for any non-emergent medical/dental surgical procedures including but not limited to tooth extractions and Root Canals. Family HealthCare will do our best to notify guardians of such procedures/paperwork before appointment date.

I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR ONE (1) YEAR OF SIGNATURE DATE.

_____ _____

Parent/ Legal Guardian Signature **Date**

_____

Parent/ Legal Guardian Printed Name