Heartland Community Health Clinic
. . . A Community of Caring

Authorization of Release of Information to Family / Friends

All areas must be completed; This Authorization must be signed and dated to be valid

Patient Name: _____ Date of Birth: _____
(Print Full Name)

Legal Representative: _____,
(Print name if applicable or write N/A for Not Applicable) (Date of Birth) (Relationship)

Authorize the Release of my Protected Health Information by Heartland Community Health Clinic to:

1-_____
(Print Name) (Date of Birth) (Relationship)

2- _____
(Print Name) (Date of Birth) (Relationship)

Patient Health Information that may be Released: _____

Restrictions, if any: _____

Purpose of Disclosure : Patient Request / Patient Representative Request

Expiration Date of Authorization
This Authorization is effective through (check one) ☐ ___/___/___ *or* ☐ **NO Expiration**, unless revoked or terminated by the patient or the Patient's Representative. (If nothing checked Expiration will be 6 months from the date of signature)

Potential for Re-Disclosure
Information that is Disclosed under this Authorization may be Re-Disclosed by the person to which it is given. The privacy of this information may not be protected under Federal Privacy Rule.

By signing this form, I am consenting to allow Heartland Community Health Clinic to give out information about my condition, treatment and/or payment to the above named person(s). I understand that I may rescind this Authorization at any time and will be requested to state this change in writing. You will need to contact the Compliance Officer to terminate this Authorization.

_____
(Signature of Patient) (Date)

_____
(Signature of Patient Representative if applicable) (Date)

_____
(Signature of Witness / Verified Patient's Identity)

Please provide a copy of signed Release to patient / patient representative. *CO - 2/11/13*