PARAGON PAINCARE

CONSENT TO RELEASE PERSONAL INFORMATION
TO
FAMILY MEMBER OR FRIEND

DATE:________________________ **PATIENT'S NAME:** ____________________________________

DUE TO OUR POLICY, AND HIPPA REGULATIONS, WE CANNOT DISCLOSE ANY MEDICAL INFORMATION TO FAMILY MEMBERS AND/OR FRIENDS. IF THE PATIENT CHOOSES TO DESIGNATE A FAMILY MEMBER AND/OR FRIEND TO OBTAIN PERSONAL INFORMATION WE REQUIRE A SIGNED CONSENT FORM FROM THE PATIENT. IN ADDITION TO THE AUTHORIZED PERSON'S NAME, RELATIONSHIP TO THE PATIENT, DATE OF BIRTH, ADDRESS AND PHONE NUMBER, THE PATIENT WILL NEED TO INDICATE EXACTLY WHAT TYPE OF INFORMATION THAT CAN BE PROVIDED. PLEASE ONLY DESIGNATE ONE INDIVIDUAL TO OBTAIN SUCH INFORMATION.

DESIGNATED RECIPIENT OF PERSONAL INFORMATION

NAME: ____ D.O.B.: ____________________

RELATIONSHIP TO PATIENT: ____

ADDRESS: ____

PHONE NUMBER: (H): ________________________________ (W):__________________________

INFORMATION APPROVED TO BE RELEASED TO THE ABOVE DESIGNATED PERSON

❑ NO INFORMATION IS TO BE RELEASED ❑ ALL MEDICAL/BILLING INFORMATION

❑ ONLY THE FOLLOWING INFORMATION MAY BE RELEASED:

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____ ________________________________
PATIENT'S SIGNATURE DATE

consentfamilyfriends.doc