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Infinity Wellness - A Center for Functional Medicine

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their parent(s), grandparents, guardians or other to call and discuss medical information, request prescriptions, vaccine information, medical records, and results of test, pick up forms, etc. Under requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

I,_____, **Date of birth**_____,

Authorize representatives of Infinity Wellness staff, to share and/or release information to:

1)_____**Relationship**_____

Check all that apply:

- ○ Regarding appointment, time & date
- ○ Discuss medical care, an issue of concern
- ○ Discuss lab results
- ○ Request and pick up /fax prescriptions/forms

2)_____**Relationship**_____

Check all that apply:

- ○ Regarding appointment, time & date
- ○ Discuss medical care, an issue of concern
- ○ Discuss lab results
- ○ Request and pick up /fax prescriptions/forms

3)_____**Relationship**_____

Check all that apply:

- ○ Regarding appointment, time & date
- ○ Discuss medical care, an issue of concern
- ○ Discuss lab results
- ○ Request and pick up /fax prescriptions/forms

I understand that I have the right to change this authorization at any time by sending a written notification to this office.

_____ _____

Patient Name (Print) **Date**

_____

Signature of Patient