



**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS**

In the event HealthCare Partners of Nevada may need to give your test results or medical information, may we.....(check all that apply)

- \_\_\_ Leave a detailed message on an answering machine.
\_\_\_ Leave a message with your spouse or family member.
\_\_\_ Call you on your cellular phone, the number is \_\_\_\_\_
\_\_\_ Call you at work, the number is \_\_\_\_\_
\_\_\_ Speak to you directly. ONLY

I, \_\_\_\_\_ (DOB) \_\_\_\_\_, give Dr. \_\_\_\_\_ and staff, authorization to disclose my protected health information to the following family, friends and/or caregivers:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records department.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy, which I obtained from my doctor's office.

Unless, otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_ If I fail to specify a date this authorization will expire one (1) year from the signature on this form.

\_\_\_\_\_  
Signature of Patient Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Guardian or Personal Representative Date \_\_\_\_\_

\_\_\_\_\_  
Signature of HealthCare Partners of Nevada employee Date \_\_\_\_\_