AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: ____

Date of Birth: ________________ PATIENT ID NUMBER:________________

I hereby authorize medical providers and personnel of Cedar Creek Internal Medicine to discuss my protected health information with:

______________________________ (Name) ________________________ (Relationship)

______________________________ (Name) ________________________ (Relationship)

______________________________ (Name) ________________________ (Relationship)

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

____ Information regarding the patient's diagnosis and treatment for HIV/AIDS
____ Psychotherapy notes from a Psychiatrist or Psychotherapist
____ Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from __________ until __________ at which time this authorization to use or disclose this protected health information expires.

- Unless specified above, this authorization will expire 365 days from the date of signing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to refuse to sign this authorization.

________________________________ ________________________________
Signature of Patient/Personal Representative Name of Patient/Personal Representative

______________________ ________________________________
Date Description of Personal Representative's Authority