FLORIDA CANCER AFFILIATES
NORTH FLORIDA

HIPPA Release

Patient's Name: ____ DOB: _________________________________

We may release your health information, including information about your condition, to a family member or friend who may be involved in your medical care or who helps pay for your care. As described in our Notice of Privacy Practices, you have the right to request that we do not release your health information to certain individuals.

Please use the form below to indicate with whom we may release your health information to notify or assist in the notification of a family member or friend who may be involved in your care.

Release of Information:

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information.

The information may be released to: *(Please be specific with names.)*

☐ Spouse ____

☐ Child(ren) ____

☐ Other ____

☐ Information is NOT to be released to anyone.

This HIPAA Release will remain in effect until terminated by me in writing.

When leaving messages:

Please call: ☐ my home ☐ my work ☐ my cell Phone: (______) _____________________________

If you are unable to reach me:

☐ You may leave a detailed message.

☐ Leave a message requesting me to return your call.

☐ Other: ____

The best time to reach me is _________________________ (*Day of the week*), between __________________ (*Time*) and __________________ (*Time*).

Signed: ____ Date: _______/ _______/ _______

Witness: ____ Date: _______/ _______/ _______