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

In the event that Independent Medical Group of Pahrump 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 discloure 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.**

_____ **Date**_____
Signature of Patient

_____**Date**_____
Signature of Guardian or Personal Representative

_____**Date**_____
Signature of IMG employee