



Release of Information Family / Personal

PATIENT NAME: _____ D.O.B. _____

Please Note: This release is for family and or personal caretakers only. A separate release is required for all healthcare providers, facilities, etc.

Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights. This information, in detail, is available at the front check in counter at all of our locations. Please take the time to read and understand your rights under HIPAA. Your signature below indicated that you have read and understood this information.

Disclosure of Protected Health Information:

I authorize my healthcare provider to disclose my Protected Health Information to the following individual(s):

Name: _____ Relationship: _____

Home Telephone: _____ Other Telephone: _____

Name: _____ Relationship: _____

Home Telephone: _____ Other Telephone: _____

Name: _____ Relationship: _____

Home Telephone: _____ Other Telephone: _____

Name: _____ Relationship: _____

Home Telephone: _____ Other Telephone: _____

[] I do not want my Protected Health Information released to family members.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Indiana Health Group. I understand that a revocation is not effective to the extent that Indiana Health Group has relied on the use or disclosure of the protected health information.

Signature of Patient or Parent/Guardian Relationship Date