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Authorization to Release Protected Health Information (PHI) to Family Members or Designated Individuals

HIPAA Laws prevent us from discussing or disclosing your protected health information to family members, friends or other designated individuals unless you provide AKMD with authorization to release this information. We are required to have a completed Authorization on file prior to releasing your protected health information.

DESIGNATION OF FAMILY MEMBERS, FRIENDS OR OTHER INDIVIDUALS

Please complete this form to designate the individuals(s) to whom we may release your Protect Health Information. Your Protected Health Information includes your medical and billing records maintained by AKMD.

I, _____
Printed Name of Patient (First Name, Middle Initial, Last Name) Date of Birth

authorize AKMD to disclose my protected health information to the individual(s) listed below:

Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient

I understand that this Authorization is voluntary and I may revoke my authorization in writing at any time, except to the extent that action has been taken by AKMD in reliance on this authorization. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the individuals listed and no longer protected under federal Law.

I also understand that by signing this form all prior Authorizations to Release Protected Health Information to Family Members or Designated Individuals are null and void as of my signature date below.

Signature: _____
Signature of Patient or Legally Authorized Representative Date

Printed Name of Legally Authorized Representative (if applicable) _____

If representative, specify relationship to the individual and attach legal documentation of your authority:

□ Legal Guardian □ Power of Attorney □ Other