Authorization to Disclose Personal Health Information

In order to provide timely communication of results to the appropriate person(s), we ask that you provide our office with the following authorization(s).

I, _____, authorize Family First Physicians, S.C. to discuss my personal heath information with the following:

☐ Patient (Please indicate which phone number(s) we may use to contact you)

- ☐ Home _____ May we leave a message? (circle) Yes No
- ☐ Work _____ May we leave a message? (circle) Yes No
- ☐ Cell _____ May we leave a message? (circle) Yes No

☐ Others (Please complete requested information)

Name _____ Relationship _____

Home _____ Work _____ Cell _____

Please indicate your selection: □ Normal results only □ All results (both normal and abnormal)

Name _____ Relationship _____

Home _____ Work _____ Cell _____

Please indicate your selection: □ Normal results only □ All results (both normal and abnormal)

Name _____ Relationship _____

Home _____ Work _____ Cell _____

Please indicate your selection: □ Normal results only □ All results (both normal and abnormal)

I, _____, authorize Family First Physicians, S.C. to provide prescriptions or medications intended for me to the following individuals. I understand that anyone other than me may be required to provide a photo ID before a prescription or medication will be released.

Name _____ Relationship _____

Home _____ Work _____ Cell _____

Name _____ Relationship _____

Home _____ Work _____ Cell _____

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Legal Guardian Date