Authorization for Release of Information to Family Members

Patient Name: _____Date of Birth: _____

Many of our patients allow family members such as their spouse, parents, children or others to call and request medical or billing information or to schedule appointments. Under the requirements of HIPAA (Patient Privacy Act), we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Michelle Liske, M.D. Inc t release my medical and/or billing information to the follow individual(s):

1. Name: _____ Relation to Patient: _____

   Phone Number: _____

2. Name: _____ Relation to Patient: _____

   Phone Number: _____

3. Name: _____ Relation to Patient: _____

   Phone Number: _____

4. Name: _____ Relation to Patient: _____

   Phone Number: _____

Patient Information: I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal law or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing.

Signature: _____**Date:** _____

Revoked: I choose to revoke the above release on the effective date below:

Signature: _____**Date:** _____