Authorization Release of Information

Patient Name_____ Patient SSN:_____ Birth date: _____

Authorization for Release Information

I authorize FAMILY PHYSICIANS OF O'FALLON, PC, to discuss my medical care and/or billing information with the following family members or other individuals as designated below. These individuals can pick up my prescriptions and will serve as my personal representative as defined by the Health Insurance Portability and Accountability Act (HIPAA). Revocation of this authorization must be made in writing to the Family Physicians of O'Fallon HIPAA Privacy Officer or Practice Manager.

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Please indicate an emergency contact below:

Name:_____ Relationship:_____ Phone #:_____

SIGNATURE:_____DATE:_____