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Release of Protected Health Information (PHI) to family members/friends

Patient Name:_____ Date of Birth:_____

Although, HIPAA allows us to share protected health information as necessary to family members or friends directly involved in your care/treatment or payment of the services provided to you, at times an authorization is required to disclose such information.

I authorize Parag B. Thakkar MD SC to release all my medical (including mental health and other specifically protected information) and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

I understand I have the right to revoke this authorization at any time by notifying in writing. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

Signature:_____ Date:_____
Patient or Legal Guardian