



## Health Information Release for Family & Friends

This document is a supplement to the Patient Registration form. In case of emergency, refer to Patient Registration for emergency contact information. The persons listed below are permitted to receive the Patient's ("Patient") health information, both verbal and written, to the extent relevant to that person's direct involvement with Patient's care and treatment or payment for care and treatment, unless or until Patient revokes their permission in writing.

| Name (please print) | Contact # | Relationship | Effective | End |
|---------------------|-----------|--------------|-----------|-----|
|                     |           |              |           |     |
|                     |           |              |           |     |
|                     |           |              |           |     |
|                     |           |              |           |     |
|                     |           |              |           |     |

\*Mark through unused spaces. Do not leave blank lines

|   |  |             |  |
|---|--|-------------|--|
| <b>Patient Name:</b><br>(please print)  |  | <b>DOB:</b> |  |
| <b>Signature of Patient / Guardian:</b> |  |             |  |
| <b>Date Signed:</b>                     |  |             |  |