

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO
FAMILY AND/OR CAREGIVERS**

In the event Back to Health Medical Center may need to give your test results or medical information, may weí í í í í ..(check all which apply)

- _____ Leave a detailed message on an answering machine.
- _____ Leave a message with my spouse or family member.
- _____ Call you on your cellular, the number is _____
- _____ Call you at work, the number is _____
- _____ Speak to you directly **ONLY**

I, _____ (DOB) _____, give Back to Health Medical Center, Dr. Cleveland, M.D. and staff, authorization to disclose my protected health information to the following family, friends, and/or caregivers:

- Name: _____ Relationship: _____
- Name: _____ Relationship: _____
- Name: _____ Relationship: _____
- Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Back to Health Medical Center.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not to sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Policy, which I obtained from my doctor's office.

Unless, otherwise revoked, this authorization will expire on the following date, even or condition:

_____. If I fail to specify a date THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE SIGNATURE ON THIS FORM.

Signature of Patient Date: _____

Signature of Guardian or Personal Representative Date: _____