[RELEASE OF INFORMATION-11/2019]

Date: _____/_____/_____

Patient Name: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, in order for your physician/provider or the staff of **My House Clinic (MHC)** to release copies of and/or discuss your condition, exams, procedures, and/or lab results with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

EMERGENCY CONTACT DESIGNATION:

_____I DO NOT authorize MHC to release any information concerning my care to any individual.

_____I authorize MHC to release any/all information including verbal information, copies of lab results and medical paperwork concerning my medical care to the following individuals:

Name: _____Relationship: _____Phone#: _____

Name: _____Relationship: _____Phone#: _____

AUTHORIZATION TO LEAVE PHONE MESSAGE:

_____I authorize MHC to leave detailed messages at the phone number listed in my medical chart.

_____I DO NOT authorize MHC to leave detailed messages on my voicemail or answering service.

***I acknowledge in choosing this option that I, the client/guardian, assume full responsibility for contacting MHC regarding any/all lab results.**

Signature of Patient/Guardian: _____ Date: ____/____/_____