

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY & FRIENDS

I hereby authorize Glendale Primary Care LLC (“GPC”) to release my Patient Information described below to:

- All of my family members
- Spouse
- Mother
- Father
- Children:
- Other Family Members:
- The following persons: _____

Documents/Information to be Released

Information/documents regarding medical treatment of the patient including diagnosis, procedures, test results

Purpose of Disclosure:

At the request of the individual

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (“HIPAA”) govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice’s compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the GPC’s Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to the attention of “The Compliance Officer”.

I understand that I am not required to sign this Authorization and that GPC may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This authorization expires when I am no longer a patient in this practice or have revoked this authorization.

I hereby acknowledge receipt of this Authorization.

I DO / DO NOT GIVE PERMISSION (Circle One) to Glendale Primary Care LLC to leave information on my answering machine and with my family members in regard to appointments, referrals and test results.

Signature of Individual or Personal Representative

Description of Personal Representative’s Authority

Date of Authorization