Authorization to Release Medical Information to Individuals and/or Family Members

Patient Name: ____________________ Date of Birth: _________________

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

_____ I do not authorize Dr. Ken Templeton to release any or all information concerning my medical care to any individual except to my other doctors and /or insurance carriers.

_____ I authorize Dr. Ken Templeton to release my medical and/or billing information to the following individual(s):

______________________________ ________________________________
Name Relationship to Patient

______________________________ ________________________________
Name Relationship to Patient

______________________________ ________________________________
Name Relationship to Patient

_____________________________________ ____________________
Patient Signature Date