Aspen
Family Medicine & Geriatrics

HIPAA Authorization Form: Release of Patient Information

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of **Aspen Family Medicine & Geriatrics** to discuss your condition 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 your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

Patients Full Legal Name:		Date of Birth	Sex M F
Mailing Address:	City	St/ Zip	
Home Phone ( )	Mobile ( )	Work Phone ( )	

I, _____, hereby authorize Aspen Family Medicine & Geriatrics and/or any medical facility to release any and all medical information and test results that pertain to me, to the following individual(s):

1. _____
   Name Phone Relation to patient
2. _____
   Name Phone Relation to patient
3. _____
   Name Phone Relation to patient

I authorize Aspen Family Medicine & Geriatrics or the medical facility to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/modify individuals above or cancel this authorization by submitting written notification to Aspen Family Medicine & Geriatrics.

_____

Patient Signature Date