McCRIMMON PRIMARY CARE plus

Disclosure & Authorization to Release Health Information to Family/Friends

Patient Name: _____ **Date of Birth:** _____

Purpose of this Form: This form allows you to tell us who we may disclosure your medical care to. This includes permission to discuss appointments, test results, billing, or other parts of your care. **You do not have to list anyone.** Care will not be affected if you choose not to authorize anyone.

Individuals Authorized to Receive Information:

☐ **I do NOT authorize disclosure to any friends/family.**

Name	Relationship	Phone Number	Information Allowed
_____	_____	_____	☐ ALL medical & billing info ☐ Medical info only ☐ Billing info only ☐ Other: _____
Name	**Relationship**	**Phone Number**	**Information Allowed**
_____	_____	_____	☐ ALL medical & billing info ☐ Medical info only ☐ Billing info only ☐ Other: _____

Specially Protected Information

Unless you check **"NO,"** the people listed above may also receive the following if applicable:

Mental health information: ☐ **YES** ☐ **NO** HIV/STD testing or treatment: ☐ **YES** ☐ **NO**

Substance use treatment: ☐ **YES** ☐ **NO** Reproductive health information: ☐ **YES** ☐ **NO**

Patient Signature

By signing below, I acknowledge that I have read and understand this form, and I authorize McCrimmon Primary Care Plus to disclose my information as described above.

Patient / Legal Guardian Signature: _____

Printed Name: _____ **Date:** _____

Relationship to Patient (if applicable): _____

Details & Expiration

- This does not permit anyone listed to make medical decisions for me
- Treatment, payment, or eligibility for benefits does not depend on signing this form
- Anyone you authorize may receive information verbally, by phone, or in writing when appropriate.
- This authorization remains in effect until you revoke it in writing or complete a new form

<u>Office Use Only</u>

Received by staff: _____ Date: _____

Scanned: ☐ Yes Entered into EMR: ☐ Yes ☐ No

Last Updated: 01/02/2026