**MEDINA FAMILY MEDICAL CLINIC**
**209 GRACE COVE**
**MEDINA TN 38355**

**Phone: (731) 783-0400** **Fax: (731) 783-0402**

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# AUTHORIZATION TO RELEASE Protected Health Information TO PERSON OTHER THAN PATIENT

Name of Patient: ______________________________

DOB: ____________ SS#: ____________

______ I have received, or been offered, a copy of the Notice of Privacy Practices.
______ I authorize the release of my medical information to the person or persons listed below.
______ I authorize the release of my billing information to the person or persons listed below.

Name(s) of authorized person(s): (Please print):

1. ______________________ Relationship: ______________
2. ______________________ Relationship: ______________
3. ______________________ Relationship: ______________
4. ______________________ Relationship: ______________

Signature of Patient: ______________________ Date: ____________

Signature of Witness: ______________________ Date: ____________

Revised 10/8/2014