

# HIPAA Patient Consent Form

## Authorization for Disclosure of Protected Health Information to Family Members

This form allows you to authorize the disclosure of your protected health information (PHI) to specified family members. Please fill out this form, print it, and sign it.

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### 1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

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### 2. Authorized Family Members

I hereby authorize the healthcare provider to disclose my protected health information to the following family member(s):

#### Family Member 1:

Full Name:

Relationship to Patient:

Phone Number:

#### Family Member 2:

Full Name:

Relationship to Patient:

Phone Number:

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### 3. Scope of Disclosure

Please specify the types of health information that may be disclosed (for example: "All medical and billing records", "Only appointment times", "Only billing and financial records"):

Authorized Information:

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### 4. Patient Acknowledgment and Signature

By signing below, I understand that this authorization is voluntary. I understand that I have the right to revoke this authorization at any time by providing written notice to my healthcare provider. Releasing this information to the designated individuals may result in the redisclosure of my information, and it may no longer be protected by federal privacy laws.

Patient Signature (or Legal Representative):

*(Sign here after printing, or type legal signature if filling digitally)*

If Representative, State Relationship to Patient:

Date Signed (MM/DD/YYYY):