Family Member Information Release HIPAA Form

Patient Information

Full Name

Date of Birth

Phone Number

Address

Family Member(s) Authorized for Information Release

Full Name(s)

Relationship(s) to Patient

Information to be Released

Purpose of Release

Authorization Duration

Start Date

End Date (or "Until Revoked")

Patient Authorization

Patient Signature

Date

Witness (If Required)

Witness Name

Witness Signature

Date