Northwest Psychiatry

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AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have you medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below.

You have the right to revoke this consent at anytime.

I authorize/ allow Northwest Psychiatry to release my medical and/ or billing information to the following individual(s).

1. _____ Relation to Patient: _____ Phone: _____
2. _____ Relation to Patient: _____ Phone: _____
3. _____ Relation to Patient: _____ Phone: _____

Patient Name: _____ DOB_____

Patient Signature:_____ Date: _____

Tel: (512) 342-7979
Fax: (512) 637-2596