Genesis Psychiatric Center
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Authorization Form for Release of Protected Health Information with Family or Friends

Patient Name:__________________________________ Date of Birth:______________________

I grant permission for my healthcare provider and their representatives of Genesis Psychiatric Center to discuss my care using this disclosure form to share relevant information about my healthcare or discuss financial information for payment on my account with family or friends.

Release my protected health information to the following person(s)/entity:

Name:______________________ Phone:____________________ Relationship:_____________

Name:______________________ Phone:____________________ Relationship:_____________

The information you may release subject to this authorization is the following:

Appointment date/time ☐Yes ☐No Explanation of diagnosis and/or procedures ☐Yes ☐No

Lab Reports ☐Yes ☐No Billing Information ☐Yes ☐No

☐**<u>I do not want any of my information shared with family or friends</u>**

I consent to Genesis Psychiatric Center to leave a message on my voicemail regarding my lab test results:
☐Yes ☐No

I understand that my healthcare information at Genesis Psychiatric Center is protected. By signing this form, you are granting Genesis Psychiatric Center to disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this information. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office. The Notice is available on our website and in our lobby. If you would like a copy please see the front desk.

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Patient/Authorized Representative Signature Date

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Genesis Psychiatric Center.