Date: _____

Patient Authorization to Release Information to Family or Non-Family Member

I, _____authorize Family Health Centers of San Diego to release to
(Print Patient Name)
_____any information regarding my provided healthcare service
(Name of Person & Relationship to Patient)
including appointment dates and times, status of my patient account (balances) and/or information in my medical records. I understand if at any time, I decide to change this authorization, I must submit it in writing within (30) days to the HIPAA Security Officer, Family Health Centers of San Diego, 823 Gateway Center Way, San Diego, CA 92101. I understand that Family Health Centers of San Diego will not be held liable if information is given to the person(s) I designate as authorized.

To ensure the highest confidentiality when receiving inquiries, the person(s) who you grant authorization to access your protected health information must know three things when asked by a staff member; your birth date, your patient account number or medical record number and your phone number, or they will be denied access to your information. There are no exceptions to this rule. Please ensure that you give the person(s) this information about you to prevent delay.

This authorization will remain in-place unless I notify Family Health Centers of San Diego in writing to replace, update, or delete this authorization. I also give the following members authorizations:

_____ _____
(Name & Relationship) **(Name & Relationship)**

By signing and dating this form, I authorize Family Health Centers of San Diego to share protected health information with my delegates.

Patient Signature: _____ **Date:** _____

Office Use Only:

*Identification Verified*_____ *Staff Name who Verified*_____

CC: copy given to patient