Five Rivers
Health Centers

Permission to Share Medical Information

_____ _____
Patient printed name *Date of Birth*

In the event I am unable to be reached by phone, please:

☐ Leave results or message with the person I have designated below

☐ Leave a message with your name and return number only

☐ Do not leave any message

Please choose from Option 1 or Option 2 below

1 ☐ **The following individuals have permission to interact with Five Rivers Health Centers on my behalf, (check each box that applies).**

☐ Receive my medical information from FRHC

_____ _____ ☐ Request prescription refills
Printed First and Last Name *Relationship to Patient*

_____ ☐ Make/ change/ cancel appointments
Phone number

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_____ _____ ☐ Request prescription refills
Printed First and Last Name *Relationship to Patient*

_____ ☐ Make/ change/ cancel appointments
Phone number

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2 ☐ **Please do not share any of my medical information as protected by HIPAA.**

I understand that this authorization shall remain in effect for one year from the date of my signature below unless I specify an earlier expiration date in this space _____ _.

I understand also, that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved (see Notice of Privacy Practices).

_____ _____ _____
Today's Date *Patient or Guardian* *Patient or Guardian printed*