Lincoln Family Wellness, P.C.

Authorization for Release of Information to Family Members

Patient Name:_____DOB:_____

SSN:_____ Address:_____

Contact Phone Number:_____

I,_____ (Patient Name), direct Lincoln Family wellness, PC to disclose and release my protected health information described below to:

Name:_____ Relationship:_____

Address:_____ Contact Phone Number:_____

Health Information to be disclosed upon the request of the person named above:

☐ **Disclose** my complete health record (including but not limited to diagnosis, test results, medications, plan of treatment and billing for all conditions).

☐ **Disclose** my health record, as above, **But DO NOT disclose** the following (check all that apply):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please Specify): _____

The authorization shall be effective until revoked. This includes all past, present and future periods unless otherwise specified.

You may revoke this authorization in writing at any time by notifying our office, preferably in writing.

Patient/Guardian Signature:_____ Date:_____