Hunt Regional Medical Partners
4501 Joe Ramsey Blvd, Suite 100
Greenville, Texas 75402

# HIPAA-RELEASE OF INFORMATION

I have acknowledged/received a written copy of the "Notice of Privacy Practices"

Patient's Name: ______________________________ Date of Birth: __________

I hereby give permission to Hunt Regional Medical Partners and/or involved medical staff to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friends.

| Name | Relationship |
| --- | --- |
| Name | Relationship |
| Name | Relationship |

______ Initial here if you **DO NOT** authorize assignment of any person(s) to communicate with Hunt Regional Medical Partners and/or involved medical staff for any reason.

I wish to be contacted in the following manner:

| Home#__________ | Cell#__________ | Work#__________ |
| --- | --- | --- |
| Ok to leave a message? Yes No | Ok to leave a message? Yes No | Ok to leave a message? Yes No |

The duration of the authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient/Representative Print Name: ______________________________

Patient/Representative Signature: ______________________________

Relationship (if other than patient): ______________________________