MRH Medical Group
East Main Family Medical
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Authorization to Release Medical Information to Individuals/Family Members

Patient Name:	Date of Birth:

It is the responsibility of **Monroe Regional Hospital Medical Group** to ensure that information regarding patients remains confidential. This means that information regarding your medical condition, billing and insurance issues, or any other protected health information as identified under HIPAA, cannot be released to other people, not even to family members, unless you authorize, in writing, the person(s) to whom you want that information released.

In the event of a critical episode, or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

We realize that there are times when you may want another person to be knowledgeable about your medical condition, or act on your behalf about billing or insurance issues. You can, if you desire, name a person(s) to whom you want the office staff to speak with about your medical condition or other issues. To do this, you must complete the form listed below.

- Only 2 (two) people can be designated for this role.
- I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.
- I understand that information disclosed to any below recipient is no longer protected by federal or state law and may be subject to re-disclosure by the below recipient.
- You have the right to revoke this authorization consent in writing.
- If you designate no one, Monroe Regional Hospital Medical Group cannot release information to any family member or friend.

Authorization:

I _____ Date of Birth _____, authorize Monroe Regional Hospital Medical Group to release any and all information concerning my medical care to the following individuals. I release Monroe Regional Hospital Medical Group and its staff from any claim or confidentiality in connection with the release of this information.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

☐ I do not wish to designated anyone at this time.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date