

Patient Health Information Release Form

North Macon Family Healthcare Associates

1) I authorize North Macon Family Healthcare Associates to release my protected health information to my insurance company for purposes of billing, collections, and prior authorization for services provided by the office.

Signature _____ Date: _____

2) I authorize North Macon Family Healthcare Associates to release my protected health information to other physicians, healthcare providers, or technicians for the purpose of continuing medical treatment, discussion, or consultation.

Signature _____ Date: _____

3) I authorize North Macon Family Healthcare Associates to communicate with any and all pharmacies, and hereby authorize said pharmacy to release information regarding my current and past pharmaceutical treatments, including drug, strength, amount, date, refills and prescriber.

Signature _____ Date: _____

4) I authorize North Macon Family Healthcare Associates to leave messages at my home and/or workplace, and/or send mail regarding appointments; need to contact the office, or other matters not involving specific medical information.

Signature _____ Date: _____

5) I authorize North Macon Family Healthcare Associates to discuss my medical condition with the following family members:

Sign Here if NONE: _____ Date: _____

Sign Here if YES: _____ Date: _____

If yes, list the names and relationship of those with whom we may discuss your care:
