

Family, Significant others and Friends. Under certain circumstances, we may disclose PHI (protected health information) to family members, other relatives, or close personal friends or others that you identify to improve communication of relevant information (most commonly laboratory results, prescription issues and or changes, appointment scheduling, etc...) to their involvement in your care or payment related to your care; or to notify them of your location, general condition or death.

In compliance with this office's HIPPA policy I am authorizing Dr. Crews or his staff to release PHI as necessary to support and assist in my care. Please list each individual authorized to receive information as stated above and provide us with the information requested. This signature is good for 1 year from date signed and may be revoked at any time by writing our office or notifying the office staff during you medical visits in the office.

Name of Family Member or Friend	RELATION SHIP	Address	Phone	Date and Signature in BOX below.
				Signature
				Date:
				Signature
				Date:
				Signature
				Date:
				Signature
				Date: