AID Upstate

Authorization to Release Medical Information to Individuals/Family Members:

In accordance with Federal government privacy rules implemented through the Healthcare portability act of 1996 (HIPAA), In order for your provider or staff of the Practice to discuss your condition with the members of your family or other individuals (**this is someone other than yourself or your provider**) that you designate, we must obtain your authorization prior to doing so.

I authorize AID Upstate to release verbally and/or information, pertaining to my medical care, to the following **family members or individuals below**. I understand this information may only be released to the individual after proper identification has been presented. The authorized person may be requested to obtain this information by appearing in person.

☐ I **do not** authorize AID Upstate to release any printed or verbal information concerning my medical care to any individual.

☐ **I authorize** AID Upstate to release verbally and/or photocopies of any of all information concerning my medical care (appointments, prescriptions, etc) to the following individuals. **NOT** to include photocopies of medical records.

Print Name	Relationship	DOB	Contact #
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Patient Printed Name: _____

Patient Signature: _____ **Date:** _____