Family Care Network
We Take Care

PERPETUAL AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION (PHI)

Perpetual Authorization to Share Protected Health Information (PHI) allows our office to discuss your healthcare information with the person(s) you list below.

Patient name: _____

Date of Birth:_____ Previous name: _____

I authorize Family Care Network to leave ***detailed messages*** for the above named patient on the phone number(s) listed here: _____

_____

I authorize Family Care Network (including all clinics, offices, and ancillary services) to share limited protected health information about my condition and care with the individual(s) listed below, who are involved in my ongoing care.

Name (print)	Telephone number	Relationship
Name (print)	Telephone number	Relationship
Name (print)	Telephone number	Relationship

You may include information specific to the following (check all that apply):

- ❑ HIV(AIDS virus)
- ❑ Mental health or illness
- ❑ Sexually transmitted diseases
- ❑ Drug and/or alcohol use
- ❑ Reproductive healthcare- **only for minors under 18 years of age**

Minors: a minor patient's signature is required in order to disclose information related to reproductive care (at any age), sexually transmitted disease (age 14 and older), HIV/AIDS (age 14 and older), drug and/or alcohol abuse (age 13 and older), and mental health or illness (age 13 and older).

Note: This form is valid until cancelled by the patient or legally authorized individual, or when a minor patient turns 18. **This form does not authorize release of any medical records.**

_____

Patient or legally authorized individual signature — Date

_____

Printed name *(if signed on behalf of the patient)* — Relationship *(parent, legal guardian, etc.)*

_____

Minor patient's signature, if applicable — Date

CANCEL AUTHORIZATION

❑ **Cancel This Authorization**

Patient signature: _____ Date: _____