WeCare
Medical Associates

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 healthcare provider or staff of Wecare Medical Associates to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. 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.

_____ I do NOT authorize Wecare Medical Associates to release any or all information concerning my medical care to any individual except as set forth above.

_____ I authorize Wecare Medical Associates to verbally release any or all information concerning my medical care to the following individuals:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Signature _____ Date: _____

Print Patient Name: _____ D.O.B. _____

Witness Signature: _____ Date: _____