Patient Name ________________________________ Date of Birth ___________________

Subscriber #: _______________________________

Many of our patients allow family members and/or legal designee such as their spouse, parents or others to call and request medical, dental or claim information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical, dental or claim information released to family members and/or legal designee, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Volusia Health Network to release my medical, dental and/or claim information to the following individual(s).

1. ____________________________________ Relation to Patient: _________________

2. ____________________________________ Relation to Patient: _________________

3. ____________________________________ Relation to Patient: _________________

<u>Patient Information</u>

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

This authorization will be in effect for the duration listed below:

Beginning Date: ______/______/______ Ending Date: ______/______/______

Signature: ____ Date: _______________