Hunt Regional Medical Partners

HIPAA-RELEASE OF INFORMATION

I have acknowledged/received a written copy of the "Notice of Privacy Practices" and "Patient Bill of Rights"

Patient's Name: _____ Date of Birth: _____

I hereby give permission to Hunt Regional Medical Partners and/or involved medical staff to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friends.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____ Initial here if you **DO NOT** authorize assignment of any person(s) to communicate with Hunt Regional Medical Partners and/or involved medical staff for any reason.

I wish to be contacted in the following manner:

Home#_____	Cell# _____	Work#_____
Ok to leave a message?	Ok to leave a message?	Ok to leave a message?
Yes_____ No _____	Yes_____ No _____	Yes_____ No _____

You may send Correspondence to my home address? Yes_____ No _____

The duration of the authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient/Representative Print Name: _____

Patient/Representative Signature: _____ Date: _____

Relationship (if other than patient):_____