

**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 Endwell Family Physicians LLP 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 Endwell Family Physicians LLP to release any or all information concerning my medical care to any individual except as set forth above.

\_\_\_\_\_ I **authorize** Endwell Family Physicians LLP 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

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Print Patient Name Date of Birth Social Security #

\_\_\_\_\_  
Witness Signature Date