KVH
Kittitas Valley Healthcare
Your Home for Health

Place patient label here.

Family and Friends Authorization

This form authorizes KVH clinics to share verbal or written medical information with third parties, e.g., family members, caregivers. It is NOT an authorization to release medical information to other physicians and/or attorneys.

I _____ , _____ , authorize KVH clinics to discuss
Patient name *Date of birth*

information regarding my health with the following person(s):

Name	*Relationship*

Please initial below what information may be shared.

_____ I authorize that all test results may be shared.

_____ I authorize my entire medical record may be shared.

_____ I authorize my financial information may be shared.

I specifically want KVH clinics to **exclude** the following protected health information from disclosure:

_____

_____

_____

Please initial below your preferences for phone contact.

_____ I hereby give permission to KVH clinics to leave messages on my voice mail/answering machine regarding appointment confirmations, scheduling changes, and/or referral information.

_____ I hereby give permission for KVH clinics to leave a message with my spouse and/or other person(s) regarding appointment confirmations, scheduling changes and/or referral information.

Name of individual(s) who this information can be left with:

_____

_____

_____

This authorization will remain in effect indefinitely. I can rescind this authorization at any time with written notification.

_____ _____
Signature of Patient or Guardian *Date Signed*

_____
Relationship or status, if signed by anyone other than patient