Family Health Care Clinic, PSC
1012 center Drive
Richmond, KY 40475

HIPAA RELEASE FORM

Patient Name:_____ Date:_____

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (Including a Spouse or Significant Other).

Please print name, relationship and telephone number for each person to whom you are authorizing release of you private health care information and account balances. This form authorizes us to leave a detailed message on the individuals listed below.

_____	_____	_____
Name	Relation	Phone #
_____	_____	_____
Name	Relation	Phone #
_____	_____	_____
Name	Relation	Phone #

This authorization will expire on:___/____/____ (fill in date if less than 1 year) or one year after being signed.

_____	_____
Patient Signature	Date
_____	_____
Witness Signature	Date