South Peninsula Hospital
Home Health

Authorization To Release Medical Information To Individuals/Family Members

Patient Name: _____ Date of Birth: _____

Many of our patients allow family members such as their spouse, parents or other individuals to request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. In order for South Peninsula Hospital Home Health to release your medical or billing information to individuals/family members, we must obtain your authorization prior to doing so. Signing this form will give information to only those individuals indicated below.

I authorize SPH Home Health to release:

- ☐ Medical Information
  - To include records regarding (shared ONLY if selected):
    - ☐ Behavior Health ☐ Substance use ☐ STI/contraception
- ☐ Billing
- ☐ Other: _____

Dates of authorization: _____ to _____ (if left blank form will not expire, unless authorization is revoked at the request of the patient in writing)

Selected information may be release to the following individual(s):

1. _____ Relationship to patient: _____
2. _____ Relationship to patient: _____
3. _____ Relationship to patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time by providing written notice to any of the SPH clinics or South Peninsula Hospital.

I understand I have the right to have a copy of this authorization.

I understand information disclosed to any recipient named above is no longer protected by federal or state law could possibly be shared by them.

Signature: _____ Date: _____