Family Medical Associates of Raleigh
Your Family Comes First

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Release of PHI Authorization Form
(For Use or Disclosure of Protected Health Information) MRN _____

Patient Name: _____DOB: _____Personal Representative Name: _____

Protected Health Information (PHI) *is information that is created, received, transmitted, or stored by Family Medical Associates of Raleigh which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, Family Medical Associates of Raleigh may not use or disclose PHI to persons other than those you specify on this form.*

If you are age 18 and older and you want someone else to also have access to your PHI, pick up prescriptions, speak with your provider or FMAR, or schedule appointments on your behalf, please complete and submit this form to the front office staff.

☐ **DECLINED:** I am declining at this time to allow anyone else, other than myself, to have access to my PHI, pick up my prescriptions, speak with my provider or Family Medical Associates of Raleigh, or schedule my appointments.

I authorize Family Medical Associates of Raleigh to disclose the PHI identified below **(mark all that apply)** to the following person(s)**.** ***These individuals will need to show a picture ID if picking up prescriptions or collecting written documents on your behalf.***

☐ **Spouse**	☐ **Relationship:_____**	☐ **Relationship:_____**
Name:_____	**Name:_____**	**Name:_____**
☐ **Entire PHI**	☐ **Entire PHI**	☐ **Entire PHI**
☐ Immunization Record History	☐ Immunization Record History	☐ Immunization Record History
☐ Office Visit	☐ Office Visit	☐ Office Visit
☐ Appointment Scheduling	☐ Appointment Scheduling	☐ Appointment Scheduling
☐ Lab Results	☐ Lab Results	☐ Lab Results
☐ Prescription Pick Up Requests	☐ Prescription Pick Up Requests	☐ Prescription Pick Up Requests

By signing below I am acknowledging that I have read and understand all aspects of the above, and I am aware that:

- I have the right to refuse to sign this authorization form and I have the right to revoke this form at any time by submitting a Cancellation of Authorization Form to the front office staff.

_____ _____

Your signature (or Signature of Personal Representative*) Date Signed

**If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.*