PO Box 227 Newton Grove, NC 28366
910.567.6194
Dental: 910.567.2646

www.commwellhealth.org

Federal privacy regulations require CommWell Health receive written permission to share your health care information with family or friends.

Patient Name:_____ Date of Birth:_____
Last First

☐ I **DO NOT** want to designate any family members or friends to whom my CommWell Health Care Team may discuss my health information with.

☐ I give my permission to my CommWell Health Care Team, their physicians, nurses, and other personnel ("Health Care Providers & medical records staff") to discuss my health information, in person or by telephone, or release copies of medical information with the following family members or friends involved in my medical care:

List family members/friends and state the person's relationship to the patient.

Family/friend name	Relationship to Patient	Phone Number

This access includes (please initial):

☐ Billing & Payment Information ☐ Appointment Information
☐ Lab Results ☐ Diagnostic Tests
☐ General medical information/condition
F

This authorization is limited to discussions regarding the following medical condition(s):

_____

(If no limitations are listed, discussions/releases will be permitted regarding any medical condition for which the patient has received care.)

Release of information under this document includes discussions with my Health Care Team and release of written medical information to the individuals named above.

- I understand that my treatment will not be conditioned upon my signing this authorization.
- I understand that I have the right to revoke this authorization in writing at any time, except to the extent that the information has already been released pursuant to this authorization. Otherwise, this authorization shall continue to be valid for one year.
- **I understand that any information disclosed pursuant to this authorization my be subject to re-disclosure by a recipient (family member/friend) and beyond the control of CommWell Health and would no longer be protected under the terms of the federal privacy rule.**

Patient's Signature: _____Date: _____

Witness:_____