PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I, ___________________________________, give my authorization to release my protected (Patient or Guardian name) health information including results of my laboratory tests, diagnostic tests, and/or other test results to the following designated representative(s):

Name: ______________________________ Relationship: __________________

Name: ______________________________ Relationship: __________________

Name: ______________________________ Relationship: __________________

Name: ______________________________ Relationship: __________________

________ May NOT be given to ANYONE OTHER THAN MYSELF
(**Initials**)

Interfaith Community Clinic has authorization to leave messages on my:

________ Home
(**Initials**)

________ Cell
(**Initials**)

______________________________________ Date: ______________________
Patient or Guardian Signature

______________________________________ Date: ______________________
Witness