

TOMMY J. MORGAN, M.D.

**AUTHORIZATION TO RELEASE INFORMATION  
TO FAMILY, FRIENDS, OR PERSONAL CARETAKERS**

Patient's Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The purpose of this form is to allow you to designate family, friends, or personal caretakers with whom we can mutually exchange Protected Health Information (PHI) related to treatment, payment, or health care operations issues. The following are a few examples of the types of information that you are authorizing us to mutually exchange with individuals designated on this form:

- *Medical* history to include symptoms, diagnoses, treatment, and prognosis.
- *Mental Health* history to include symptoms, diagnoses, treatment, and prognosis.
- *Substance Abuse* history to include symptoms, diagnoses, treatment, and prognosis.
- Results from laboratory studies, radiological examinations, and other tests.
- Results from mental health screening forms or psychological testing.
- Past, present, and future appointment times as well as compliance with appointments.
- Medication names, dosages, purposes, results, and compliance as well as pharmacy used.
- Insurance or other third-party payment information and history.
- Billing information to include insurance, bills, payments, returned checks, and balances.

Individuals authorized for mutual release of Protected Health Information as described above:

Name	Relationship	Contact Information

\_\_\_ Please check here if you **do not** want information exchange with family, friends, or caregivers except for a situation in which someone's safety is at risk.

If you designated individuals above, please indicate the manner in which we may communicate:

\_\_\_ Written    \_\_\_ Face-to-Face    \_\_\_ Telephone    \_\_\_ Facsimile    \_\_\_ Electronic

Please indicate a time period for this authorization. You may revoke the authorization earlier if you like:

\_\_\_ One year    \_\_\_ Other: \_\_\_\_\_

\_\_\_ Please check if you would like for a photocopy of this authorization to be as valid as the original.

\_\_\_\_\_  
Signature of Patient or Guardian                      Printed Name of Patient or Guardian                      Date Signed

\_\_\_\_\_  
Signature of Witness                                              Printed Name of Witness                                              Date Signed