2051 W Warner Rd, Ste 5
Chandler, AZ 85224
Tel (480) 399-7957

Citrus Medical Center

Authorization to Release Records to Family Members

Patient Information (Please Print):

Name: _____ Date of Birth:
Phone:_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under HIPPA requirements, we are not allowed to release this information without the patient's consent. If you would like us to release billing or medical information to family members you must sign this form. Only the family members listed below **CAN** have access to your records.

1. _____ .Relationship to Patient:_____

2. _____ .Relationship to Patient: _____

3.. _____Relationship to Patient: _____

Please list any family members that you **DO NOT** want Citrus Medical Center to discuss your medical or billing information with:

1 ._____

2 . _____

3 . _____

By voluntarily signing this form I affirm that I am the above patient, parent or legal guardian and have read and fully understand all statements made in this document. I understand that I have the right to revoke this authorization at any time by providing a written statement to Citrus Medical Center where the authorization was originally submitted, except to the extent that Citrus Medical Center has already completed action on it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. **I understand that this authorization will remain in effect indefinitely unless revoked in writing by the patient or legal representative.**

Patient's Signature | Date

Parent/Legal Representative Signature/Relationship To Pt | Date