DAYSPRING FAMILY MEDICINE

CONSENT FOR RELEASE OF MEDICAL INFORMATION TO FAMILY

I consent to the disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of care:

Names and DOB:

_____

_____

_____

Check all that may apply

__ All of medical information

__ Information necessary to schedule appointments

__ Lab or test results

__ Information regarding prescription and/or medical equipment to call in or pick up

__ Information to help my family member(s) to take care of me

__ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient of Dayspring Family Medicine Associates unless and until I notify Dayspring Family Medicine Associates in writing of any changes.

_____

Signature of Patient or Representative and Date

_____

Patient Name and DOB

_____

Name of Representative to Patient

Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statue, N.C.G.S. 8-53, and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The consents of this form can be combined with such existing consent forms.