

## HIPPA Authorization Form for Family Members/Friends/Caretakers

I, \_\_\_\_\_, authorize the following person(s) to have access to know and understand my condition, my treatment and treatment options.

\_\_\_\_\_  
Name(Printed)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Name(Printed)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Telephone Number

This authorization shall be effective until (check one):

All past, present, and future periods, OR

Date or event: \_\_\_\_\_

Unless I revoke it. (Note: You may revoke this authorization in writing at any time by notifying our office.)

\_\_\_\_\_  
Signature of the Individual Giving this Authorization

\_\_\_\_\_  
Date