FCHC Medical Group

Communication Release Form

Last Name_____ First Name_____ MI_____ Date of Birth_____

FCHC Medical Group strives to keep your Protected Health Information (PHI) and personal information secure. Requests, usage and disclosure of information is only granted to meet the intended need. You may change your Authorized Representatives at any time.

❑ **DO NOT DISCLOSE** any information to anyone but me.

Authorized Representatives

I give permission for the following people to receive information as specified. Please mark all that apply.

Primary Contact

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

Secondary Contact

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

Additional Contact

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

Additional Contact

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

_____ _____

Patient/Authorized Representative Signature Date