AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION FOR FAMILY MEMBERS OF PATIENTS

I, ____
(Name of Patient) (Date of Birth)

____
(Address) (Phone Number)

Authorize Sheboygan Physicians Group, S.C. to discuss in person or by telephone protected health information with the following family members:

Name	Relationship	Home/Cell Phone #

The specific type of information to be disclosed is as listed below

( ) 1. All Health Information

( ) 2. Specify items or particular interest____

____

The purpose of need for this disclosure is: ( ) Medical Care ( ) Insurance purposes
( ) Billing ( ) Other____

The authorization for disclosure of information is effective:___________________ __(no longer than one year)
(Dates and/or condition)

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to Sheboygan Physicians Group, S.C., 2920 Superior Avenue, Sheboygan, WI 53081. I understand that a revocation is not effective to the extent that Sheboygan Physicians Group has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may by subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Sheboygan Physicians Group, S.C. will not condition my treatment, payment, enrollment in a health plan or eligibility, for benefits (If applicable) on whether I provide authorization for the requested use or disclosure.

Authorization **MUST BE SIGNED BY PATIENT. Parent or legal Guardian** is **to sign** if **patient** is a **minor or** is mentally or physically incompetent.

________________________ ______________________________________
(Date) (Patient Signature)

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(Signature of Parent or Legal Guardian)