Uvalde Family Practice Assn.
1800 Garner Field Road • Uvalde, TX 78801 • PH (830) 278-4453 • FAX (830) 278-3427

Authorization for Release of Information to Family Members or Family Caregivers

Patient Name: _____ Date of Birth: _____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

☐ I do not authorize to release my medical and/or billing information.

☐ I authorize Uvalde Family Practice Association to release my medical and/or billing information to the following individual(s):

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time, any revocation must be in writing.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. Uvalde Family Practice Association has no control over third party dissemination of protected medical information.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Name (printed): _____