EXPRESS CARE
Of Ocala
The ER Alternative

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request results of tests, procedures, financial information. Under the requirements of H.I.P.A.A. we are not allowed to give any of this information, to anyone without the patient's consent. If you wish to have your medical information released to any individuals/family members you must sign this form.

The facility, its employees and physicians are hereby released from any liability for the disclosure of the information released therein. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Express Care of Ocala to release any or all information concerning my medical care to the following individuals.

Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone

Patient Name (Print)	Date of Birth	Social Security #

Patient Signature	Date
Witness Signature	Date