GUTHRIE

RELEASE OF PATIENT INFORMATION TO
FAMILY, FRIENDS AND OTHERS INVOLVED IN YOUR CARE

According to The Guthrie Clinic Providing Medical Information to Family, Friends, and Others Directly Involved in Patient's Care – the person must be clearly involved in the patient's care or payment for care in order to share the protected health information. This may be someone who is known to be a family member or personal representative of the patient, someone whom the patient says is involved in his or her care, or someone whose involvement is obvious.

This authorization grants permission to my family, friends or others involved in my care, "Designated Party," named below to: make or confirm appointments; have access to pertinent medical information; have access to telephone communication as well as other common means of communication; be made aware of my diagnosis, treatment and prognosis; and have access to my financial health information.

I hereby authorize The Guthrie Clinic entities (including RPH, Corning Hospital, Cortland Hospital, Troy Hospital, Robert Packer Hospital Towanda Campus and all Guthrie clinics) to use and disclose my protected health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to the individual(s) named below, the released information may no longer be protected by Federal privacyregulations.

Patient Name:_____ Date of Birth:_____

Designated Party:_____ Relationship to Patient:_____

Phone: (Home)_____ (Cell)_____

Address:_____
(Street) *(City)* *(State)* *(Zip)*

Designated Party:_____ Relationship to Patient:_____

Phone: (Home)_____ (Cell)_____

Address:_____
(Street) *(City)* *(State)* *(Zip)*

The information will be used or disclosed for the following purposes:

☐ At the request of the individual. ☐ Other:_____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will: (must check one)

   ☐ expire one year from the date signed by the patient or patient's representative; **or**

   ☐ be effective for the lifetime of the patient unless revoked (see #2 below)

2. **Initials**:_____ I understand that I may revoke this authorization at any time by notifying The Guthrie Clinic in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by The Guthrie Clinic prior to their receipt of the revocation.
3. **Initials**:_____ I understand that my treatment cannot be conditioned on whether I sign this authorization.
4. **Initials**:_____ Specially protected information that may be disclosed includes:
   - information relating to AIDS or HIV.
   - information relating to psychiatric or other mental health treatment.
   - information about treatment for drug, alcohol, or substance abuse
   - information relating to genetic diseases/tests

_____ _____
Signature of patient or patient's representative **Date**

_____ _____
Printed Name of Patient's Representative Relationship to Patient:

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION* Access to eGuthrie requires other forms to be filled out. Access refers to verbal information or paper information obtained through the Medical Records department only.**