HILTON HEALTH CARE, P.C.- Family Release

Patient Name: _____ Date of Birth: _____
(please print)

I give Hilton Health Care, P.C. permission to communicate with the following people about my (or my child's) medical care:

Name (please print)	Relationship	Phone #

Release of information including: (please check all that apply)

- ( ) making & changing appointments
- ( ) diagnosis information
- ( ) medication requests/refills/PICK UP PRESCRIPTIONS
- ( ) plan of care
- ( ) patient billing
- ( ) above release includes drug/alcohol treatment
- ( ) above release includes mental health treatment
- ( ) above release includes HIV tests/treatment

I understand that this will remain in effect until I state otherwise; I can rescind this authorization at anytime.

_____ _____
Printed Name Date

_____ _____
Signature Relationship (Self/Parent/Other)

People I need to delete from my authorization list.

_____ _____