Steven A. Crews, DO, PA HIPPA Friend and Family Informational RELEASE 352-360-0654

Family, Significant others and Friends. Under certain circumstances, we may disclose PHI (protected health information) to family members, other relatives, or close personal friends or others that you identify below to improve communication of relevant information (most commonly laboratory results, prescription issues and or changes, appointment scheduling, etc…) to their involvement in your care or payment related to your care; or to notify them of your location, general condition or death. WE must have COMPLETE information in order to verify their identity. THIS does not authorize them to make health care decisions or DNR orders. THIS for INFORMATIONAL purposes only. This form is revalidated annually.

In compliance with this office's HIPPA policy I am authorizing Dr. Crews or his staff to release PHI as necessary to support and assist in my care. Please list each individual authorized to receive information as stated above and provide us with the information requested. This signature is good for 1 year from date signed and may be revoked at any time by writing our office or notifying the office staff during you medical visits in the office.

Name of Family Member or Friend	RELATION SHIP to you	Their Address	Their Phone number

Date of completion of this form: ______/_______/________ Signature: ____

Revalidation Date:______________________ Revalidation Signature:____

Revalidation Date:______________________ Revalidation Signature:____

 NAME: DOB