PATIENT AUTHORIZATION TO COMMUNICATE WITH FAMILY / CAREGIVER

What This Form Does:
Allows Lakeview Clinic to talk with the person(s) you listed about your care (appointments, updates, and selected health information).

What This Form Does NOT Do:
Does **not** allow them to get copies of your medical records. A separate authorization is required.
Does **not** give them permission to make healthcare decisions for you.
Applies to **verbal communication only** (in person or by phone).
No patient portal access is included.
You can **change or revoke this at any time** and choose what information is shared.

Patient Information			
Name:	Street Address:		
Date of Birth:	City:	State:	Zip:
MRN:	Primary Phone #:		

1. Individuals Authorized
I authorize the following individual(s) to receive information about my care and communicate with my healthcare team:

Name:	Name:
Relationship:	Relationship:
Phone #:	Phone #:

2. Information That May Be Shared
☐ Appointment scheduling and reminders
☐ General health information and treatment updates
☐ Test results and care plans
☐ Billing and insurance information
☐ All health information (unless otherwise restricted)

Sensitive Information (optional – patient choice)
☐ Mental health information
☐ Substance use disorder (alcohol/drug treatment) information (may require additional authorization under federal law)
☐ HIV/STD or other communicable disease information
☐ Psychotherapy notes (if applicable)
Patient initials: _____

3. Purpose of Disclosure
Information may be shared for purposes of care coordination, communication, and assistance with my healthcare.

4. Expiration -
☐ One (1) year from the date signed
☐ On this date*: _____
☐ Upon my written revocation
***Minors must have expiration date of 18th birthday if earlier expiration date is not selected.**

5. Patient Rights
I understand I may revoke this authorization at any time in writing and that this authorization is voluntary.

6. Signature
Signature: _____
Printed Name: _____
Date Signed: _____

ROUTE COMPLETED FORMS TO FRONT OFFICE For office use only Entered in PM _____ Entered in EMR_____