



# TAHOMA CLINIC

## Release of Information FRIENDS AND FAMILY AUTHORIZATION

The name(s) listed below are family members or friends to whom I wish to grant access to my health care information. I will on the professional judgment of my provider and his/her designee to share such information as they deem necessary.

I understand that some information is considered "sensitive". I understand that I must check the specific boxes in order for my provider or his/her designee to release any "sensitive" information.

- Mental Health/Psychiatric Disorders (including depression)\*
- Chemical Dependency (drug and/or alcohol abuse/treatment)\*
- HIV/AIDS Virus\*
- Sexually Transmitted Diseases\*

\* A minor patient's signature is required in order to release information concerning care for: 1) Conditions relating the minor's sexuality including, but not limited to: contraception, pregnancy and sexually transmitted diseases (age 14 and above); 2) Alcohol and/or drug abuse (age 13 and above); and 3) Mental health conditions (age 13 and above).

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date as I recognize that relationships and friendships may change over time.

Name	Relationship to Patient
1. _____	_____
2. _____	_____
3. _____	_____

### EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

- Home    Work    Mobile

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Minor Releasing Info: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_