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:** _____