

## **Medical Records Release Form to Family**

If you would like for us to be able to discuss your health care information with any family members, relatives or friends, please fill out this form:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

By signing this form, I authorize Ashburn Family Healthcare to release/discuss ALL protected health information about me to:

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

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

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

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so by presenting my written revocation to Ashburn Family Healthcare. The revocation will not apply to information that has already been released in response to this authorization.

Signed: \_\_\_\_\_

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