

Patient Authorization for Family/Friend/Other to Receive Health Information

Patient Name	Date of Birth
Patient or Legally Authorized Representative	e to complete the following:
I authorize NUNM Health Center to discuss/prov	vide the information specified below to the following individual:
Name:	
PRINT name of person to receive information	Date of Birth
Patient or Representative needs to INITIAL the desired information	on to be disclosed:
Recent Patient Visit	_
Care Instructions	_
Prescription Information	_
• Lab Results	
Billing	
Appointment information including	the right to schedule, change, and cancel appointments
Specify any other restrictions or release of information	on to the party specified above:
This authorization is valid as of and e	expires as of (up to one year later).
	this consent form. I also understand that I have the right to revoke this to NUNM Health Center. I understand that my written revocation is not uthorization was in effect.
Signed: Patient or Legally Authorized Representative	Date:
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Witness:	Date: