Urban Family Practice Associates, P.C.

PERMISSION TO SPEAK TO FAMILY MEMBERS (PSFM)

PLEASE SELECT A OR B

A. _____ I, _____ decline having any of my medical/billing information released to anyone.

B. _____ I,_____ give permission for Urban Family Practice physicians/and or staff to release or discuss lab results or any other information including but not limited to information in my medical/billing record with the following person(s).

_____Relationship_____

_____Relationship_____

_____Relationship_____

This release of information shall be in effect until revoked by me in writing.

_____	_____	_____
Patient's Signature	Date of Birth	Date
_____	_____	
Patient's Printed Name	Account Number	
_____	_____	
Witness	Date	

(HIPAA/Forms/6. PSFM
04/14/2003)