Midnight Sun Family Medicine, P.C.
S. Gayle Hornberger, D.O. ~ Carrie L. Conley, PA-C

HIPAA CONSENT FOR PATIENT MEDICAL INFORMATION RELEASE

Patient Name: _____Pt. Date of Birth: _____/_____/_____

Patient Former Name/s:_____

Medical Care Dates: ___/___/___ to ___/___/___

I authorize MIDNIGHT SUN FAMILY MEDICINE, P.C. to release my personal health information to family members or others involved in my care or assisting me with financial payment arrangements.

*****Name:_____Relationship:_____

Phone # or contact information:_____

*****Name:_____Relationship:_____

Phone # or contact information:_____

*****Name:_____Relationship:_____

Phone # or contact information:_____

PRIVACY INFORMATION: Please circle YES or NO for the following statements. By circling YES for the following statements this office will leave voicemail or answering machine messages at your home, work, cell, or emergency contact on file that may include your protected health information and may be overhead by others not involved in your care.

Location	**Call back/Message**	**Detailed Message**
Home	Yes / No	Yes / No
Work	Yes / No	Yes / No
Cell	Yes / No	Yes / No
Emergency contact	Yes / No	Yes / No

Patient Signature:_____Date:____/____/____

Witness: _____Date:____/____/____

This form will remain in effect for ONE YEAR from the date of signature. Any changes to this form must be submitted, by the patient, on a new form, signed, dated and witnessed by an MSFM Staff Member .

Midnight Sun Family Medicine, P.C.
Excellence in Family Medical Care