FCCR
Family Care Clinic

HIPPA RELEASE & CONSENT FORM

Patient Name: _____ **Date of Birth**: _____

Parent/Guardian (if child is under the age of 18): _____

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends, and other relations regarding you or your child(ren)'s medical care. Each person you wish to be considered a contact must be listed individually.
Please list below anyone who is authorized to bring your child in for medical treatment.

Please print name, relationship, and contact number for each person whom you are authorizing release of your private health care information.

Name	Relation	Phone #
Name	Relation	Phone #
Name	Relation	Phone #
Name	Relation	Phone #

This authorization will expire on: ____/____/____ or one year after being signed.

Patient Signature: _____ **Date**: _____

Clinic Personnel: _____ **Date**: _____