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FAMILY & FRIENDS RELEASE OF PROTECTED HEALTH INFORMATION

This is NOT a release of information or records to insurance companies or other doctors or facilities.

PLEASE TELL US WHAT FAMILY & FRIENDS WE CAN TALK TO ABOUT YOU. For your privacy, when YOU OR YOUR FAMILY OR FRIENDS call our office we will first need to verify the identity of the caller. We will not speak with anyone not listed below.

LIST FAMILY OR FRIENDS, if any, whom we may inform about your general medical condition and your diagnosis [List additional family or friends on the back of this page]:

NAME: RELATIONSHIP: PHONE NO:
[Blank lines for input]

\*\*\*\* [Initials] May speak with ANYONE regarding my medical condition or diagnosis.

Please list the family or friends, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

NAME: RELATIONSHIP: PHONE NO:
[Blank lines for input]

\*\*\*\* [Initials] May speak with ANYONE regarding my medical condition or diagnosis.

- 1. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent IF OTHER THAN YOUR HOME.
2. Besides you, whom may we speak with regarding your account?
3. Do you want all correspondence from our office sent in a sealed envelope marked CONFIDENTIAL?
4. Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information, if OTHER THAN your home phone number:
5. Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail?
6. If you do not have voicemail, can a confidential message be left at your place of employment?

PATIENT NAME: DATE OF BIRTH:

PATIENT/RESPONSIBLE PARTY/GUARDIAN SIGNATURE:
DATE:

If at any time you would like to change the information you have provided us, please let us know. Thank You.