TEAMWORK HEALTH
BETTER TOGETHER

TeamWork Health Consent for Release of Protected Health Information to Family

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of my care:

1. **Name:**_____ **Phone:** _____ **Relationship:** _____

2. **Name:**_____ **Phone:** _____ **Relationship:** _____

3. **Name:**_____ **Phone:** _____ **Relationship:** _____

Check all that apply:

- ☐ All of my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family member(s) to pick up or arrange for medical equipment to be provided to me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient at TeamWork Health, unless and until I notify TeamWork Health in writing of any changes.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____**Date:** _____

Relationship to patient: _____

*Please call **(919) 883-1583** if you have questions regarding this policy document.*
*For questions regarding your bill, please e-mail **billing@twhasg.com**.*

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