Sparrow

1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

Communication with Family & Friends Involved in My Care or Payment of My Care

Patient's Name:_____ Birth date:_____

Address:_____ Phone No.:_____

City/St/Zip:_____

Patients may allow family and friends, such as spouse, parent(s), significant others, guardians or others, to call and discuss medical information, request prescriptions, obtain vaccine information, request test results, pick-up completed forms (i.e., FMLA, sport physicals), and have messages left on answering machines or voicemail. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's written or verbal consent.

Completion of this form authorizes release of the information identified above, to the individuals indicated below.

This authorization may be revoked at any time by submitting a written request.

I authorize representatives of Sparrow Health System and its affiliates to share and/or release my information to:

1. Name: _____ Phone #: _____ Relationship: _____
   Check all that apply:
   - ☐ Regarding appointments, dates & times
   - ☐ Discuss lab/test/x-ray results
   - ☐ Discuss vaccines
   - ☐ Discuss medical care, issues or concerns
   - ☐ Request and pick-up completed forms
   - ☐ Other (describe) _____

2. Name: _____ Phone #: _____ Relationship: _____
   Check all that apply:
   - ☐ Regarding appointments, dates & times
   - ☐ Discuss lab/test/x-ray results
   - ☐ Discuss vaccines
   - ☐ Discuss medical care, issues or concerns
   - ☐ Request and pick-up completed forms
   - ☐ Other (describe) _____

3. Name: _____ Phone #: _____ Relationship: _____
   Check all that apply:
   - ☐ Regarding appointments, dates & times
   - ☐ Discuss lab/test/x-ray results
   - ☐ Discuss vaccines
   - ☐ Discuss medical care, issues or concerns
   - ☐ Request and pick-up completed forms
   - ☐ Other (describe) _____

I understand that the individual receiving my information is not a health care provider or health plan covered by state or federal privacy laws and regulations and that the information described above may no longer be protected by those laws and regulations.

I understand that I may revoke or change this authorization, in writing, at any time, by sending notification to the Sparrow Health Information Management.

_____ _____
Signature of patient Date & Time