Family Care
ASSOCIATES
www.familycareassociates.com
1106 N Merchant Street
P.O.Box 665
Effingham, IL 62401
Ph: 217-342-7000 Fax: 217-342-7002

Authorization for Confidential Communication

Release of Medical Information

I, _____, hereby give Family Care Associates of Effingham, S.C. permission to
(Name of Patient or Authorized Agent)

release_____ _____ Protected Health Information these individual(s):
(Patient's Name) (DOB)

_____	_____	_____
Name DOB	Relationship	Telephone #
_____	_____	_____
Name DOB	Relationship	Telephone #
_____	_____	_____
Name DOB	Relationship	Telephone #

I understand that this request is valid until it is revoked by me. I understand that I may revoke this request at any time by giving written notice of my desire to do so to Family Care Associates of Effingham, S.C. I also understand that I will not be able to revoke this request in cases where the physician has already relied on it to disclose my confidential Protected Health Information. Written revocation of the request must be sent to Family Care Associates of Effingham, S.C. I understand that additional restrictions for Confidential Communication may be requested.
This Request for Confidential Communication Form supersedes all previous Requests for Confidential Communication Forms.

Release of Prescriptions/Samples

I, _____, give consent for the following person/persons to pick up my prescriptions and/or samples**. This person must be 18 years of age and must present identification at the time of pick up.**

_____	_____
Name DOB	Relationship to patient
_____	_____
Name DOB	Relationship to patient
_____	_____
Name DOB	Relationship to patient
_____	_____
Signature	**Date**

If you are not the patient, please specify your relationship to the patient: _____