

Patient Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_

**Limited Release of Information to Family/Friends for Physician Clinics**  
**HIM# 1315s**

**I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below.** These individuals will only be given information about me that is related to their involvement in my care or payment for my care.<sup>1</sup> I understand that I am not required to complete this form in order to obtain health care.

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_ Talk to this person about (*check each box that applies*):

Any non-sensitive<sup>2</sup> information regarding my health care or payment for my health care.

**OR**

Only these things:

My appointments – scheduling & reminders	My test results
My after visit summary (AVS)	My bills
Other:	

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_ Talk to this person about (*check each box that applies*):

Any non-sensitive<sup>2</sup> information regarding my health care or payment for my health care.

**OR**

Only these things:

My appointments – scheduling & reminders	My test results
My after visit summary (AVS)	My bills
Other:	

**If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.**

\_\_\_\_\_  
DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): \_\_\_\_\_

<sup>1</sup> This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

**This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.**

<sup>2</sup> Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**

