

FAMILY PRACTICE ASSOCIATES  
509 HAMACHER ST, SUITE 102  
WATERLOO, IL 62298

HIPPA Phone Information Release Authorization

**IMPORTANT! PLEASE READ CAREFULLY AND SIGN**

This consent authorizes Family Practice Associates (FPA) to release detailed information including your test results, follow-up recommendations, treatment plans, etc. This information will be shared in detail via voicemail or to person(s) who have access to the numbers you deem acceptable for us to share this information and provide to us below.

**Please indicate to which number(s) we may leave detailed information:**

	YES	NO
_____ HOME	_____	_____
_____ CELL PHONE	_____	_____
_____ WORK	_____	_____
_____ ALTERNATE #1	_____	_____
_____ SIGNATURE (Patient or Representative)	_____	_____
	DATE	

**WARNING**

I understand that if the individual I have authorized to receive the information is not a health plan or health care provider; therefore, released information may no longer be protected by federal privacy regulations.

**NOTICE OF RIGHTS**

You may refuse this Authorization. You may revoke this Authorization at any time. Your revocation must be in writing, signed by you or on your behalf and delivered to FPA. Your revocation will be effective upon receipt. You have a right to receive a copy of this Authorization. Treatment, payment, enrollment and eligibility for benefits will not be conditioned on your providing or refusing to provide this Authorization.