EAST GRANBY FAMILY PRACTICE, L.L.C.
13 CHURCH ROAD
P.O. BOX 518
EAST GRANBY, CT 06026
PHONE: (860) 653-4526
FAX: (860) 653-5209

AUTHORIZATION TO RELEASE INFORMATION

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Act does not allow for unauthorized disclosure to a patient's family members, friends, or advisors. If the patient would like their protected health information release to someone other than himself or herself they must complete the bottom half of this form. A patient cannot specify which information they would like released to this third party. By completing this form, all protected information may be released to the third party upon request until this agreement is terminated in writing.

I,_____, give East Granby Family Practice,

Permission to discuss with

_____ _____
(Print name) (Relationship to patient)

_____ _____
(Print name) (Relationship to patient)

_____ _____
(Print name) (Relationship to patient)

_____ _____
(Print name) (Relationship to patient)

Permission to leave message on

_____ Home telephone answering machine # _____

_____ Work voice mail # _____

_____ Mobile phone voice mail # _____

Any information pertaining to my healthcare.

Signature: _____

Print Full Name: _____

Date: _____

Witness: _____
(Sign and print full name) This must be physician or staff member of EGFP.