Jones Family Care APRN, LLC

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HPI Jones Family Care APRN, LLC

Authorization to Release Information via Phone/Family/Friends

Patient Name: _____ DOB: _____

I hereby authorize confidential communications to and or from the **Nurse Practitioner or staff of Jones Family Care** with the individuals listed below regarding my health, care, treatments, prescriptions, etc. by in person, phone calls, or voice messages.

Name	Phone Number	Relation

I understand that this authorization will remain in effect until I revoke the authorization in writing.

_____ _____

Patient Signature / Legal guardian Relationship / Date

STAFF ONLY
Documented by: Initials _____ Date _____