COMMUNICATING WITH FAMILY AND OTHERS RELEASE FORM

Patient Name: _____ DOB: _____

Patient Address: _____

Address City State Zip Code

Patient Social Security Number: _____ Physician: _____

The Siouxland Medical Education Foundation may release medical information about you to a family member, personal representative or friend who is involved in your medical care or who helps pay for your care. Please list any family members or others who may be involved in coordinating your care or payment for care. Indicate what kinds of information may be shared with each individual.

Name	**Relationship to Patient**	**Type of Information**			
		All	*Scheduling/ Appointment*	*Medical*	*Billing/ Insurance*
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐

Please identify any specific instructions or limitations: _____

_____

_____

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify the clinic if you wish to alter the designations above. To revoke this authorization, please send a written request with a copy of this form to the clinic.

_____ _____

Signature of Patient or Legal Representative: Date:

_____ _____

Signature of Witness: Date:

Siouxland Medical Education Foundation
2501 Pierce Street
Sioux City, IA 51104

If you have any questions please call the clinic at 712-294-5000