AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

We require your signed consent in order for us to provide any medical information about you to anyone other than one of your healthcare providers or your medical insurance company.

I ______________________________, hereby grant permission to the physicians or staff of Primary Care Specialists, LLC, to release information related to my condition, including data about mental illness, alcoholism, sexually transmitted diseases, HIV, AIDS, and the use of drugs or any other medical information to the following individuals:

NAME	RELATIONSHIP
______________________________	__________________
______________________________	__________________
______________________________	__________________

ADVANCE DIRECTIVES

In order to comply with Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statues, please answer the following questions

DECLARATION OF DECLINE LIFE PRO LONGING PROCEDURES (LIVINGWILL)

( ) I have made such a declaration ( ) I have **not** made such a declaration

HEALTH CARE SURROGATE

( ) I have designated a Health Care Surrogate ( ) I have **not** designated a Healthcare Surrogate

DURABLE POWER OF ATTORNEY

( ) I have appointed Durable Power of Attorney ( ) I have **not** appointed Durable Power of Attorney

ACKNOWLEDGEMENT FORM

Our notice of Privacy Practices information about how we may use and release protected health information about you. You have the right to review our notice before signing this form. You have the right to restrict how protected health information about you is used or released for treatment, payment, or health care operations. By signing this form you consent to our use and release of protected health care operations as described in our notice. You have the right to revoke this consent in writing, except where we have already made releases in reliance on your prior consent.

______________________________ __________________

Signature Date