THRIVE CENTER FOR PERSONALIZED HEALTHCARE AND WELLNESS
AUTHORIZATION FOR RELEASE OF INFORMATION – COMPOUND RELEASE (FRIENDS & FAMILY)

Patient Name: ____ **Date of Birth:** ________________________

Thrive Center for Personalized Healthcare and Wellness is authorized to release protected health information about the above-named patient in the following manner and to identified persons.

Name of Person to Receive Information: ____

Relationship to Patient: ____

The following communications can be given to the person above. Check options that can be shared.
Some items may be left blank.

Lab results/X-rays
Financial Information
Medical Information
Appointment Reminders
Breach of Information Notification

Selected information can be communicated to the person above in the following ways.
Some items may be left blank.

Voicemail (Please provide contact person's phone number: ______________________________________)
Text Message (Please provide contact person's phone number: ____________________________________)
For text message communication, I understand that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect text communication as selected.
Email (Please provide contact person's email address: ____)

Patient Rights:

- **I have the right to revoke this authorization at any time.**
- **I may inspect or copy the protected health information to be disclosed as described in this document.**
- **Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.**
- **Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.**
- **I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.**
- **This authorization will remain effective until revoked by the patient.**

X ____ **X** _________________________________

Signature of Patient or Personal Representative **Date**