HOT SPRINGS
HEALTH PROGRAM

Notice
Communication Release Form

To: Patients of the Hot Springs Health Program

Many times our patients want us to communicate with their family or friends who are assisting the patient or payment for their treatment. Please list below any family or friends whom you authorize us to discuss your care or billing information.

Name	Relationship	Phone Number
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This authorization will remain in effect until you revoke it. This authorization is for communication only. If you want someone to have a copy of your medical record, please request a medical authorization form. There may be a charge for copies of your medical record.

Patient's Name (Please Print)

Patient's Signature (***If patient is under 18, Signature of Parent/Guardian is needed***)

Patient's Date of Birth

Date Signed