



Authorization to Access Information and Treat

This form tells your clinic team who they can talk to about your health.

I _____, (printed adult patient name & date of birth)

hereby authorize Waco Family Medicine staff to disclose all my health information to the following individual(s) until further notice is given.

OR

For _____, (printed minor patient name & date of birth)

Please list individuals Waco Family Medicine can contact in the event of an emergency or release your health information to:

NOTE: You must designate at least one Emergency Contact

Emergency Contact? (Circle Yes or No)	Release other health information? (Circle Yes or No)	*Consent to Treatment (Circle Yes or No) Minors ONLY
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	Yes / No	Yes / No	Yes / No
(Name) (Relationship) (Contact Information)			
	Yes / No	Yes / No	Yes / No
(Name) (Relationship) (Contact Information)			
	Yes / No	Yes / No	Yes / No
(Name) (Relationship) (Contact Information)			
	Yes / No	Yes / No	Yes / No
(Name) (Relationship) (Contact Information)			

Patient/Parent Signature

Date

- **Emergency Contact** – A person Waco Family Medicine may contact in case of a medical or safety emergency.
- **Release Other Health Information** – Authorizes Waco Family Medicine to share your protected health information with this person (for example, about appointments, test results, or treatment plans).
- **Consent to Treat (Minors Only)** – Grants permission for this non-legal guardian (at least 18 years old) to consent to medical treatment for your child in your absence.