Archangel Michael Health

HIPAA Authorization for Family/ Friend Communication

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Version v2026.07.02 · Effective June 10, 2026

1. Patient Information

LAST NAME _____ FIRST NAME _____ MI _____

DATE OF BIRTH _____ TODAY'S DATE _____

2. Notice of Privacy Practices Acknowledgment

_____ **Initial here:** I have received and/or reviewed a copy of Archangel Michael Health, PA's Notice of Privacy Practices (NPP). I understand that the NPP provides information on how my protected health information (PHI) may be used and disclosed.

3. Communication Consent

General Contact & Follow-Up

I consent to being contacted regarding appointments, test results, and care-related matters.

☐ I consent to general contact and follow-up

Photos/Recordings

For patient care, documentation, or security purposes.

☐ I consent ☐ I do not consent

Email/Text Communications

For instructions, reminders, and health education.

☐ I consent ☐ I do not consent

> **Note on texting security:** Standard SMS text messages may not be encrypted and are not fully secure. As described in our Practice Policies, the Practice secures its texting workflow with a one-time passcode (OTP) and a PIN that expires every 15 minutes to protect against spoofing, and offers Microsoft Teams as a secure-texting alternative for clinical content.

4. Authorization to Disclose Health Information to Family/Friends

☐ I authorize **Archangel Michael Health, PA** to discuss my health information (including scheduling, treatment, payment, and other healthcare operations) with the individuals listed below. This may include information about diagnosis, lab results, billing, medications, and other relevant health matters.

NAME	RELATIONSHIP	CONTACT INFORMATION

Sensitive information (psychiatric, HIV/AIDS, genetic testing) may also be disclosed unless specifically excluded in writing.

Exclusions (if any): _____

I understand that I can revoke or modify this authorization in writing at any time.

5. Information Release & Expiration

Release of Information: By signing, I understand that my health information may be disclosed for treatment, payment, or healthcare operations as detailed in the NPP. This may include sharing with healthcare entities, third-party payers, or information exchanges.

Expiration: This authorization remains valid until I revoke it in writing or until:

Date: _____ or **Event:** _____

If no date/event is specified, this authorization remains in effect until revoked.

6. Prescription Pick-Up Authorization (Optional)

I authorize the following individual(s) to pick up prescriptions on my behalf:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

☐ I do not authorize anyone else to pick up prescriptions

7. PATIENT SIGNATURE

I have reviewed and understand this HIPAA Authorization for Family/Friend Communication. I voluntarily sign this form and acknowledge that I understand the contents.

PATIENT/LEGAL REPRESENTATIVE SIGNATURE _____ DATE _____

PRINTED NAME _____ RELATIONSHIP TO PATIENT (IF NOT SELF) _____

Please attach legal documentation if you are the patient's guardian, Power of Attorney, or other representative.

Office Use Only · Date Received: _____ Staff/Privacy Officer Signature: _____

☐ Photocopy/scanned copy placed in patient file

Thank you for trusting Archangel Michael Health, PA with your healthcare needs.
Questions? Phone: 352-441-9110 | Secure Fax: 352-441-9114 | Secure Email: manager@archangelmichaelhealth.com
A photocopy or fax of this signed form is considered as valid as the original.