Ami Laws, MD

Authorization to share or release information to designated individuals other than the designated emergency contact(s)

Please complete this form if you have a personal assistant/assistant or if you wish Dr. Laws to communicate your PIH to other family members other than your designated emergency contact.

Patient: _____ **Date of Birth:** _____

Check one box:

☐ **I am authorizing Dr. Ami Laws and Staff to share my Protected Health Information with the following individuals. This includes allowing them to pick up lab information, prescriptions, referral information and to make and receive phone calls and emails regarding my health and/or the billing related to the services provided by Dr. Ami Laws and Staff.**

1) Name: _____ Relationship to patient: _____

Address: _____

Phone: (H): _____ (C): _____

2) Name: _____ Relationship to patient: _____

Address: _____

Phone: (H): _____ (C): _____

3) Name: _____ Relationship to patient: _____

Address: _____

Phone: (H): _____ (C): _____

☐ **I am NOT authorizing Dr. Ami Laws and Staff to share my Protected Health Information with anyone.**

_____ _____

Patient Signature Date

900 Welch Road, Suite 103, Palo Alto, CA 94304 Phone: (650)325-3200/ Fax: (650)325-3200