# *O*ptima Behavioral Health, Inc.

## Family and Friends Consent Form

The following form grants Optima Behavioral Health, Inc. (associated providers and staff) your consent to communicate with your designated family members and/or friends below regarding your healthcare. Please indicate what type of information may be disclosed by checking off the appropriate box for each individual listed.

Individuals listed will not be able to request and obtain copies of your medical records, in any format, unless that individual is an authorized personal representative on your account (a separate form is required for that type of record disclosure). The sharing of insurance/billing issues may lead to the disclosure of diagnosis and procedure codes used during your visits. Appointments scheduled by your family/friends will still be your responsibility, applicable no show or late cancellation fees will apply.

You may remove individuals from accessing your account at any time by contacting the medical records department at 614-759-5075 ext. 226.

**Individual 1** | ☐ **Friend** ☐ **Family**, relation: ______________________________________

| **First Name:** | **Last Name:** |
|---|---|
| **Primary Phone Number (include area code):** | **Detailed Voice Mail:** ☐ YES ☐ NO |
| **Health Information to Share:**<br>☐ Appointments/Scheduling ☐ Insurance/Billing Issues ☐ Make Payments<br>☐ Pick-up Medication/Samples ☐ No Restrictions | |

**Individual 2** | ☐ **Friend** ☐ **Family**, relation: ______________________________________

| **First Name:** | **Last Name:** |
|---|---|
| **Primary Phone Number (include area code):** | **Detailed Voice Mail:** ☐ YES ☐ NO |
| **Health Information to Share:**<br>☐ Appointments/Scheduling ☐ Insurance/Billing Issues ☐ Make Payments<br>☐ Pick-up Medication/Samples ☐ No Restrictions | |

| **Patient Name:** | **Date of Birth:** |
|---|---|
| **Signature:** | **Date:** |