Authorization for Release or Disclosure of Protected Health Information (PHI)

Your health and medical information are considered sensitive, private and are afforded protection under the law. However, there may be circumstances when you want to grant someone other than yourself access to your Protected Health Information. There may also be times when you may want us to communicate lab results, medication(s), treatment plans or billing information through phone, voicemail messaging or email. In order to protect your privacy, we need your written permission to release and/or disclose your Protected Health Information (PHI). You have the right to revoke or limit this access at will.

Patient Name:

Patient Date of Birth:

RELEASE AND DISCLOSURES

Please indicate your preference(s)* below:

Patient Home Voicemail	☐ I CONSENT	☐ I DO NOT CONSENT
Patient Cell Phone Voicemail	☐ I CONSENT	☐ I DO NOT CONSENT
Patient Work Voicemail	☐ I CONSENT	☐ I DO NOT CONSENT
Patient Email	☐ I CONSENT	☐ I DO NOT CONSENT
Spouse Name/Phone: ___________________________	☐ I CONSENT	☐ I DO NOT CONSENT
Attorney/Phone: _______________________________	☐ I CONSENT	☐ I DO NOT CONSENT
Other/Relationship/Phone: ________________________	☐ I CONSENT	☐ I DO NOT CONSENT
Translator/Phone: ______________________________	☐ I CONSENT	☐ I DO NOT CONSENT

**Your preferences will remain in effect until you revoke them in writing*

REVOCATION AND LIMITATIONS

☐ Revocation of Prior Consent
I wish to rescind or stop all prior release and/or disclosure preferences related to my Protected Health Information.

☐ Changes to Prior Consent
I wish to make the following changes to my prior release and/or disclosure preferences. List all changes below:

Patient Signature: Date:

Patient Representative: Date: