

CONFIDENTIAL COMMUNICATION REQUEST AUTHORIZATION

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have information released, you must complete and sign below.

Would you like to give permission to the doctor and staff to release health information to additional family members, legal guardians, etc.?

No, I would not like to release my health information to anyone

Yes, I would like to release my health information to the following person(s) below:

Name Relationship Phone Number

Name Relationship Phone Number

I authorize the use of the following means of communication for information related to my personal health, medical treatment, or payment/billing information.

Please select all that apply:

- Cell phone
- Home phone
- Work phone
- Text message
- Voicemail message
- Written communication to mailing address: _____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed.

I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient.

I have the right to revoke this consent in writing.

Signature: _____

Date: _____

Print Name: _____