

Authorization to Release Medical Information

I am authorizing the following person(s) to have access to my medical records.

_____ (relationship)
_____ (relationship)
_____ (relationship)

NONE _____

Patient Signature: _____

Date: _____

Authorization to Contact Patient

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of to the individual's home.

I wish to be contacted in the following manner (check all that apply)

_____ Home Telephone: _____

- _____ okay to leave message with detailed information
- _____ leave message with call-back number only
- _____ leave appointment reminder information

_____ Work Telephone: _____

- _____ okay to leave message with detailed information
- _____ leave message with call-back number only
- _____ leave appointment reminder information

_____ Written Communication:

- _____ okay to mail to my home address
- _____ okay to mail to my home or work address
- _____ okay to fax to this number _____

_____ Other

_____ okay to leave message on this cell phone number: _____

Your Physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If this is a conflict for you, you have the right to use another Healthcare Professional.

Patient Signature: _____

Date: _____