

**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: \_\_\_\_\_

The Practice's Privacy Notice has been provided to me prior to my signing below. I have had a chance to ask questions and/or have concerns addressed. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment of me and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and had encouraged me to read the Privacy Notice carefully prior to my signing this consent. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me. I have read and understand the above statements, and all of my questions have been answered to my full satisfaction in a way that I can understand.

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: \_\_\_\_\_