

AUTHORIZATION TO COMMUNICATE PATIENT'S MEDICAL INFORMATION

COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE

(Signed original to be placed in the central medical record and copy to patient)

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| <u>PATIENT IDENTIFICATION</u> |
| Name: _____ |
| Date of birth: _____ |
| S.S. #: _____ |
| Medical Record/Account#: _____ |

| |
|-----------------------|
| Office Name: _____ |
| Address: _____ |
| City/State/Zip: _____ |
| Phone number: _____ |
| Fax number: _____ |
| Physician name: _____ |

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

| NAME: | RELATIONSHIP TO PATIENT | TYPE OF INFORMATION | | | |
|-------|-------------------------|---------------------|----------------------------|---------|-----------------------|
| | | ALL | Scheduling/ Appointment | Medical | Billing/ Insurance |
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Specific instructions or limitations: _____

Validation code: _____ (Please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. **You are authorizing those listed to receive your protected health information.** Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/Legal Representative: _____ Date: _____

Relationship to patient: _____