PERMISSION TO COMMUNICATE PROTECTED HEALTH INFORMATION

1. I grant permission to The HealthCare Connection to disclose health information of the following individual as specified below:

Patient Name: _____ Date of Birth:
_____(Please Print)

2. I authorize the information to be disclosed as specified below:

❑ On my voicemail at **home** (specify phone number): _____

❑ On my voicemail at **work** (specify phone number): _____

❑ On my **cell** via text or voicemail (specify phone number): _____

❑ To the following member(s) or other person(s):

_____/_____/_____
Name Relationship Phone Number

_____/_____/_____
Name Relationship Phone Number

3. The type and amount of information to be disclosed is as follows: (Please check appropriate boxes)

❑ Laboratory results

❑ Medical instructions or advice

❑ X-Ray reports

❑ Prescription drug information

❑ Appointment information, including confirmation/cancelation of appointment and type of appointment

❑ Do not leave any information on voicemail; attempt to contact me directly.

I understand that this may include detailed personal medical information including medical services to be provided, notification that items such as refills are ready for pick-up, as well as any information listed in #3 above.

_____ _____
Signature of Patient or Authorized Person Representative Date
(Please attach applicable legal documentation of authority)

This consent form will expire when revoked in writing by the patient/representative or in the case of a minor, on the date the minor becomes an adult under state law, whichever occurs first.