

Patient Authorization to Disclose Protected Health Information to Family/Friends/Others
****MUST BE COMPLETED BY PATIENT, PARENT OR LEGAL GUARDIAN OF MINORS*****

I, _____ understand Paris Family Physicians, P A and the office staff is authorized by me to disclose my protected health information by telephone or in person to only the people that I have listed below and in the manner that I have checked below.

How do I elect to be contacted for appointment reminders: _____ By Voice Call _____ By Text using this phone number: _____

For all other communication, I wish to be contacted in the following manner (check all that applies):

Home Telephone _____ (list home number here)

OK to leave message with detailed information Leave message with callback number only

Cell Phone _____ (list cell number here)

OK to leave message with detailed information Leave message with callback number only

Work Telephone _____ (list work number here)

OK to leave message with detailed information Leave message with callback number only

Written Communication

O.K. to mail to my home

NAME(S) OF PERSON(S) authorized by this form to disclose my protected health information which includes authorization to disclose medical information & appointment information. If not completed on this form, we are not authorized to discuss any type of medical information with others not involved in your medical team, including spouses and adult children:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

I understand that I have the right to revoke anyone listed on the authorization and must fill out the form before the revocation can be completed. All revocations must be sent to Paris Family Physicians, P.A. to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer. I fully understand and accept the terms of this authorization.

Patient's or Representative's Signature

Date