Patient Authorization to Disclose Protected Health Information to Family/Provider of care

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.

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

[ ] Home Phone ________________________

[ ] Cell phone __________________________

[ ] Work phone _________________________

[ ] 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 Signature *Date*

YEARLY REVIEW & UPDATES

DATE	SIGNATURE

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FOR OFFICE USE ONLY

Authorization added to medical record on __________________ **by** __________________________________