PHI Communication Resource Tool

Please print below information

I, ______________________________, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below (45CFR, 164.502(F) & 164.502(G):

Authorized family member or person to receive verbal information for the above named patient's care:

______________________	______________________	______________________
Name of Central Contact (Other than patient)	Relationship to Patient	Phone

Others authorized to receive my verbal information (please list names and relationship):

______________________	______________________	______________________
Print Name	Relationship to Patient	Phone
______________________	______________________	______________________
Print Name	Relationship to Patient	Phone

____

Email

♦ Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations.

♦ Do you wish to be a confidential or non-published patient for directory status? ☐ Yes ☐ No
(Example: If you are in our facility seeking treatment and a visitor calls or stops in to see you do you want to remain private and we will not acknowledge you as a patient? Confidential patients will not receive mail or flowers.)

♦ Leave message on answering machine? ☐ Yes ☐ No
(Example: We may leave message reminders, scheduling changes or notices that lab results are in on your answering machine. Would this process be acceptable, yes or no?)

♦ Leave message for patient to return call? ☐ Yes ☐ No
(Example: We may leave a message regarding appointment reminders, scheduling changes or notices that lab results are in with an individual who answers the phone. Would this process be acceptable, yes or no?)

Patient or Legal Personal Representative: ______________________________ Date: ____________________
(SIGNATURE)

Patient or Legal Personal Representative: ______________________________ Relationship to Patient: ____________
(PRINTED NAME)

Note: Except to the extent that action has already been taken in reliance on this PHI Communication Resource Tool, at any time I can revoke this PHI Communication Resource Tool by submitting a notice in writing to the Privacy Site Coordinator or Privacy Site Designee.

Patient Name: ______________________________

MRN #: ______________________________

Date of Birth: ______________________________