GENESIS MEDICAL GROUP SM

PATIENT AUTHORIZATION TO COMMUNICATE AND DISCLOSE PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner *(Check All That Apply):*

☐ **Home Telephone**
- ○ Leave message with detailed information.
- ○ Only leave message with call back details.

☐ **Cell Telephone**
- ○ Leave message with detailed information.
- ○ Only leave message with call back details.

☐ **Work Telephone**
- ○ Leave message with detailed information.
- ○ Only leave message with call back details.

☐ **Written Correspondence**
- ○ Mail to my home address on file.
- ○ Mail to my work/office address:

_____

_____

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand that the identity of designees must be verified before release of PHI.

Authorized Designees:

Name:_____Relationship:_____Telephone: (____)_____-_____

Name:_____Relationship:_____Telephone: (____)_____-_____

Name:_____Relationship:_____Telephone: (____)_____-_____

Name:_____Relationship:_____Telephone: (____)_____-_____

This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke this authorization in writing.

- ***I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.***
- ***I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.***

_____ _____ _____

Patient/Legal Representative Print Name | Patient/Legal Representative Signature | Date

☐ **REVOKE/CANCEL THIS AUTHORIZATION**

_____ _____

Patient/Legal Representative Signature | Date