Longs Peak Family Practice

Patient's Authorization to Release Medical Information/Leave Private Messages

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties below with whom I wish Longs Peak Family Practice to discuss my medical condition(s).

I understand this form will remain in effect unless revoked by me. If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform Longs Peak Family Practice in writing of my decision.

In accordance with the above, I (PATIENT NAME):_____,

hereby authorize Longs Peak Family Practice to
release my medical information to the following individuals.

☐ SELF ONLY or NAME: _____ NAME: _____

NAME: _____ NAME: _____

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above, I must designate it here by stating what information is to be excluded;

_____

_____

The below individuals are authorized to
pick up any written prescriptions.

☐ SELF ONLY or NAME: _____ NAME: _____

NAME: _____ NAME: _____

NOTIFY IN CASE OF EMERGENCY:

NAME: _____ PHONE NUMBER: (____) _____

AUTHORIZATION TO LEAVE PATIENT MESSAGES: The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care. This includes communicating with patients at their homes, whether through the mail, by phone, or in some other manner. In addition, the Rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individual's privacy, covered entities should take care to limit the amount of information disclosed on the answering machine. For example, a covered entity might want to consider leaving only its name and number and other information necessary to confirm an appointment or ask the individual to call back.

A covered entity also may leave a message with a family member or other person who answers the phone when the patient is not home. The Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present; however, professional judgment should be exercised.

The HIPAA Privacy Rule also prohibits the practice from using or disclosing patient protected health information (PHI) outside the Notice of Privacy Practice without the authorization of the patient. Messages that contain patient PHI, such as test results, medications, treatment plans, payment information or patient condition information, require the patient to sign an authorization form to receive messages by fax, e-mail, voice mail, or any other means by which someone other than the patient might reasonably have access to the message, thereby potentially violating the patient's privacy rights under HIPAA. You may elect to have your PHI provided to you, or the named individuals below, via a message from the physician's office by signing this form in the space provided below. Once you have signed the form, future communication containing PHI may be communicated to you or the following designated individuals, as indicated below.

I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, for me with either of the individuals listed below or by e-mail, fax or voice mail at the numbers noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information.

☐ **SELF ONLY: Patient Name:** _____ **DOB:** _____ **Fax #** _____

Personal Voicemail #: _____ **Patient E-mail:** _____

OR

Relative/Friend: 1) NAME: _____ PHONE #: (_____) _____

2) NAME: _____ PHONE #: (_____) _____

Patient/Legal Guardian Signature:_____ DATE: _____

LPFP WITNESS_____