Parker Family Care

Consent to Communicate Personal Health Information

Patient Name:_____ **Today's Date:**_____

By completing this form, you can identify individuals with whom we can discuss your routine health information such as lab results and future appointments.

1. With whom may we discuss your health information? (Please remember this does not apply to reminder texts and emails made from our automated appointment reminder system to your phone or email unless you request that we discontinue this service.)

- ☐ No one
- ☐ The people listed below:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

2. We will leave a message including <u>detailed personal medical information</u> except about the following topics: (please indicate below the types of information about which you do <u>NOT</u> want us to leave a message.)

3. I authorize Parker Family Care to give the persons listed above:

- ☐ **FULL DISCLOSURE OF PHI** (Protected Health Information)
- ☐ LIMITED DISCLOSURE OF PHI (<u>Excludes</u> information regarding sexual activity, alcohol, drugs, psychological & psychiatric records, STD, AIDS/HIV).

4. For Pediatric Patients: may we communicate with your child's school, daycare, or childcare provider about your child's health care?

- ☐ Yes
- ☐ No

This form does not apply to psychotherapy notes as defined by the Privacy Rule *45 CFR 164.501.*. **(for release of pediatric psychosocial health information use PBH-016; for release of adult psychotherapy notes, use HIP-008)**

I also understand that this authorization is giving Parker Family Care the right to discuss my medical information with the one or more people listed above. I may revoke this authorization at any time.

Finally, I understand the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.

Patient's signature Date of Birth

Signature of Patient, Parent or Authorized Personal Representative Date