Protected Health Information (PHI) Communication Consent Form

At Complete Cardiac and Vascular Care, we would like to understand your preferred method(s) of communication and obtain your consent for releasing medical information to family members and other individuals of your choice. You give us permission to relay your medical information such as lab results, prescription requests, appointment reminders, and referrals via phone, fax, post mail, or other specified methods as selected below. You also give us permission to release medical information to your family members, caregivers, or other selected individuals according to your preferences below. By signing this form, you understand that you have the right to revoke this authorization in writing at any time. Revocation will not cover information released prior to that date. This form is optional and does not expire. Your request will be in effect until you notify our practice of any changes.

Name: ______________________________ DOB: ____________ Medical Record #: __________

Methods of Communication (check all that apply):

Home Telephone: ______________________

Leave a voice message
Do not leave a voice message

Work Telephone: ______________________

Leave a voice message
Do not leave a voice message

Cell Phone: ______________________

Leave a voice message
Do not leave a voice message
Text message

Written Communication:

Send to home address
Send to work address
Fax to this number: ____________________

Secured e-messaging through Online Patient Portal (must be 18 years of age or older)
Email to access patient portal: ____

Messaging via Healow & ECW

Others: ____________________________

Permission(s) (check all that apply):

I do not want my medical information to be communicated to my family members or caregivers

I give this practice the permission to verbally communicate my medical information to family members, caregivers, or other individuals listed below:

Name: ________________________________ Phone: ______________________

Relation: ____________________

Name: ________________________________ Phone: ______________________

Relation: ____________________

Information to be released/accessed (check all that apply):

Appointment Information   Prescription Drug Information   Referral Information

Lab Results   Medical Instructions/Advice   Billing, Insurance, & Payment Information

X ____
Patient/Guardian Signature

____
Date

____
Print Name

____
DOB