VERBAL DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

HIPAA (The Health Insurance Portability and Accountability Act) gives you the right to request that we communicate financial and or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please complete the following. This form will tell us how you wish to be contacted and with whom we may discuss your healthcare, insurance and billing questions.

I give permission for (Select Preferred Method):

Confidential messages (such as appointment reminders, normal test results) may be left on voicemail or sent via text.

☐ Cell Phone#_____ Prefer ☐ Text ☐ Voicemail

☐ Home Phone # _____

I hereby authorize Creekside Medical to release PHI to the person(s) listed below: (i.e. spouse, family members, friends, caregiver, etc.).

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

I understand that I may revoke this authorization at any time by notifying Creekside Medical in writing and the revocation will be effective on the date noted, except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy regulations.

Patient or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)