St. Joseph Regional Health Network

Patient Consent for Use and Disclosure of Protected Information

Patient Name: _____ **Date of Birth**: _____

With my consent, the above mentioned practices may use and disclose protected health information (**PHI**) about me to carry out treatment, payment and healthcare options (**TPO**). Refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

In order to keep you informed of your medical care, we would appreciate you completing the following (initial next to your selections):

_____ May leave a message that any of the above practices tried to reach you by telephone.
Initial

_____ May leave a detailed message that any of the above practices called regarding lab results, prescription information, etc. on your answering machine / voice mail.
Initial

_____ May mail any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
Initial

_____ May leave a detailed message with ONLY the following people:
Initial

Name	Relationship

I UNDERSTAND THAT:

- I may revoke this Authorization at any time and the revocation will not apply to information that has already been released in response to this Authorization.
- I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.
- I must revoke this Authorization in writing.
- I may get a copy of this form after I sign it.

The above mentioned practices may call me by legal name in public areas of the office such as the waiting room. If I do not agree with this I will inform the front desk staff immediately. The office will restrict how it uses or discloses my PHI to carry out TPO in accordance to our privacy rules, regulations and applicable law; however, the practice is not required to agree to my requested restrictions. By signing this form, I am consenting to the above practices use and disclosure of my PHI to carry out TPO.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law. Unless otherwise revoked, this authorization will expire yearly from the date of signature.

_____ _____

Signature of Patient or Legal Guardian Date