MERCYHEALTH

Patient Name:_____

DOB: _____

Communication Release of Information

The Privacy Rule generally requires healthcare providers to take reasonable steps to minimize the Protected Health Information (PHI) requests, usage and disclosure for only what is required to meet the intended need. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

NOTE: Uses and disclosures for reasons other than treatment, payment, or operations may be permitted without prior consent in a medical emergency.

_____ DO NOT PROVIDE health information regarding blood work, appointments, and test results to anyone but me.

_____ I give permission to receive my health information regarding normal test results in a voice mail message.

Authorized Representatives

I give permission for the following people listed to receive the following PHI elements as specified below.

Name_____ **Relationship** _____**DOB**_____

Contact Telephone #_____

___ Appointments ___ Billing ___ Test Results ___Discuss my condition and treatment

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___ Appointments ___ Billing ___ Test Results ___Discuss my condition and treatment

My signature below acknowledges that I provided the information above.

Signature of Patient/Legal Guardian _____**Date** _____