AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications with Patients and their Families, Friends, or Caregivers

This form authorizes **Oyster Point Family Practice** to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and a trusted family member, friend, or caregiver.

Patient Name: _____

Date of Birth: _____ **Primary Contact Number:** ( ) _____ **Home Work Cell**

COMMUNICATING WITH YOU

PHONE	DETAILED MESSAGES PERMITTED		
☐ Primary Contact Number Above	☐ via text (SMS)*	☐ voicemail/answering machine	☐ None
☐ Other: ( ) _____ ☐ Home ☐ Cell* ☐ Work	☐ via text (SMS)*	☐ voicemail/answering machine	☐ None

EMAIL

☐ _____

☐ All information from this practice* ☐ Data breach notifications

☐ Billing and appointment information only (no treatment information)

* By checking this box, you confirm that you understand that email and standard SMS messaging are not confidential and are unsecure methods of communication. You also understand that sending your health information via email and standard SMS presents a risk that a third party could intercept and read your information.

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may orally communicate to the family members, friends, or caregivers listed below.

Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance

Spouse/Partner: _____ (First and Last) Phone: ( ) _____

Name: _____ (First and Last) Name: _____ (First and Last)

☐ This practice may **NOT** communicate with my family members, friends, or caregivers.

ACKNOWLEDGEMENT AND SIGNATURE

- You acknowledge that information related to a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse might be included in a communication you authorize on this form. Information that has been shared as permitted by this form may be redisclosed and no longer protected by state or federal privacy laws.
- You can revoke or stop the communications on this form at any time in writing. It will not apply to any communications that were made before our practice received your written notice to stop the communications.
- An Authorization to Release Health Information or Patient Access Request must be completed for this practice to provide copies of or transmit your health information/records to anyone other than you.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative.

_____ Date

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation if not previously provided)

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