MUNSON HEALTHCARE

Form #3073 (02/18)

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

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

HIPAA Privacy allows Munson Healthcare (MHC) and business associates to disclose the minimum necessary protected health information (PHI) to family members or friends who are responsible for or appear to be involved in your medical care or your health care bills. MHC may also notify your family or friends of your location and condition in the event of an emergency or disaster.

HIPAA and MHC policy allows us to leave messages at the phone number you provide regarding appointment reminders, prescription refills, or referral/testing arrangements. **You may agree to these uses of your PHI or you may ask us to limit our use of your protected health information.** For example, you may request we use another phone number or an email, or another address.

1. Do we (MHC and business associates) have your permission to contact you by the phone number(s) you provided to us? ☐ YES ☐ NO

2. Do we have your permission to send you unencrypted text or emails, using the contact information you provided? ☐ YES ☐ NO

Please list the individual(s) such as family, friends or supports with whom we may share your medical information:

Name:_____

Relationship:_____Phone Number:_____

Name:_____

Relationship:_____Phone Number:_____

I understand that the above permissions will stay in effect unless I notify MHC of changes.

_____

Signature of Patient or Patient's Legal Representative **Date** **Time**

_____

Print Name of Patient or Patient's Legal Representative

PATIENT ID LABEL