Authorization to Communicate Personal Medical Information

Plumsteadville Family Practice

Please help us honor your preferences for communicating with you by choosing among the following options. Highly sensitive information regarding mental health, substance abuse, sexually transmitted diseases, pregnancy and HIV will be discussed ONLY with you, the patient. Phone messages left by our office, will be limited to appointment reminders and request to call the office back.

ONLY in the event of a true emergency we may contact (other than yourself):

Name: _____ Relation: _____Phone: _____

Regarding general medical information (HIPAA) please initial only the one that applies:

_____I wish for my medical information to be given directly to me, the patient, **only**.

OR

__X_____In addition to myself, I authorize Plumsteadville Family Medicine to discuss my healthcare with the following individuals:

Name: __Camp Onas Staff__ Relation: __Acting In Loco Parentis__ Phone: (610) 847-5858_____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

OR

_____I request all discussion of my healthcare to be with:

Name: _____ Relation: _____ Phone: _____

I have read and agree with both forms, which includes The Notice of Privacy (HIPAA) and Authorization to Communicate my personal medical information, which gives my consent.

_____ _____

Patient Name (Printed) Date of Birth

_____

Signature of Patient (if 18yrs or older) **Today's Date**
Or Legal Guardian

8/2017