AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBER OR OTHER PERSONS

Patient Name: _____ Address: _____

Date of Birth: _____

Phone #: ( ) _____

PRIVACY QUESTIONAIRE

1. Please list the names of the family members or other persons, if any, whom we may inform about your
   ____ Medical Condition, Diagnosis, or Lab reports ____ billing inquiries on your account
   We require three identifiers on each person listed, this is to ensure that we are giving the information to the appropriate person.

   Name: _____ Relationship to patient: _____
   Please give three identifiers: SS #_____ Date of Birth_____ Mother's Maiden Name _____

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   Name: _____ Relationship to patient: _____
   Please give three identifiers: SS #_____ Date of Birth_____ Mother's Maiden Name _____

2. Can confidential messages (i.e., appointment & outpatient service reminders) be left with a family member that answers your home phone? _____ YES _____ NO

3. Can confidential messages (i.e., appointment & outpatient service reminders) be left on your home phone answering machine or voicemail? _____ YES _____ NO

4. Please list the telephone number, if any, where you want to receive calls about your appointments, lab & x-ray results, or other health care information.
   Telephone Number: ( ) _____
   This is my (circle one): HOME / WORK / CELL / OTHER

STATEMENTS OF UNDERSTANDING

1. I authorize the release of information contained in my patient records, including alcohol and drug abuse protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, Behavioral Health, if any, HIV/AIDS related records, if any, and social services records, if any, including communications made by me to a social worker, to the individuals or organizations listed above, only under the conditions listed below.

2. I understand that if a person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

3. I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization, excepting the instance of research related treatment or when the provision of healthcare to me is solely for the purpose of creating protected health information of disclosure to a third party.

4. I understand that this consent is subject to revocation at anytime. I understand that if I revoke this authorization, I must do so in writing and obtain and file a revocation form with the HIM Department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

5. This authorization will expire 1 year from date filled out, unless otherwise revoked. If this authorization is for a use or disclosure of PHI.

6. Allegiance Health will strive to meet your health information needs, but does reserve the right to receive reasonable notice of request and reasonable time to complete request.

_____ _____
(Signature of Witness) (Signature of Patient)

Date: _____ Date: _____