RELEASE OF PATIENT INFORMATION

In general, the HIPPA privacy rule gives a patient the right to request all uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication correspondence to the individual’s office instead of the individual’s home. This information will remain in effect until revoked in writing.

I consent and authorize the release of any NORMAL or ABNORMAL test results to the following persons and wish to be contacted in the following manner:

Please list name and contact number to those that apply.

☐ MY SPOUSE ______________________________________________________
☐ MY PARENT(S) __________________________________________________
☐ MY CHILD(REN) ________________________________________________

Please contact me by:

☐ Cell Phone _______________________________ Ok to leave detailed message YES or NO
☐ Home Phone _______________________________ Ok to leave detailed message YES or NO
☐ Work Phone ______________________________ Ok to leave detailed message YES or NO
☐ Email ________________________________________________

☐ E-mail is restricted to conditions and situations that do not require immediate attention. Only normal lab results will be sent via e-mail.

☐ When unable to contact me by phone, a written communication may be sent to my home address.

PRINTED NAME: ____________________________________________________________________
SIGNATURE: _______________________________________________________________________
DATE: _____________________________________________________________________________