AUTHORIZATION FOR RELEASE OF INFORMATION
VIA VOICE MESSAGE AND/OR TO DESIGNATED RELATIVES

Patient's Full Name: _____ Date of Birth: _____

Can confidential messages (i.e., appointment reminders) be left via voicemail on the mobile phone number in your patient record?

☐ Yes ☐ No If you need to update your mobile number, please speak with the Health Center Service Specialist.

Communication to Designated Relatives

Many of our members allow family members such as their spouse, parents or others to call and discuss medical or billing information, vaccine information, request prescriptions, medical records, results of tests, etc. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the member's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

I hereby request Cerner Health Connections, Inc. d/b/a Healthe Clinic, to share information with:

1. _____ Phone: _____ Relationship: _____

Check all that apply:

☐ Regarding appointment, time & date
☐ Request & pick up/fax prescriptions/forms
☐ Discuss medical care, an issue or concern
☐ Discuss vaccines
☐ Discuss billing information
☐ Confidential messages can be left if no answer

2. _____ Phone: _____ Relationship: _____

Check all that apply:

☐ Regarding appointment, time & date
☐ Request & pick up/fax prescriptions/forms
☐ Discuss medical care, an issue or concern
☐ Discuss vaccines
☐ Discuss billing information
☐ Confidential messages can be left if no answer

3. _____ Phone: _____ Relationship: _____

Check all that apply:

☐ Regarding appointment, time & date
☐ Request & pick up/fax prescriptions/forms
☐ Discuss medical care, an issue or concern
☐ Discuss vaccines
☐ Discuss billing information
☐ Confidential messages can be left if no answer

Patient Acknowledgement

- This authorization will expire one year from signature. I can change or revoke this authorization at any time by delivering a written revocation to the Healthe Clinic. If I revoke this authorization it will have no effect on actions already taken in reliance on it.
- I understand that certain records/information may be protected by federal or state law, including HIV, psychiatric, behavioral or mental health treatment, alcohol, drug treatment or communicable diseases, and, unless otherwise specifically indicated, I am requesting that any and all such protected records be released under this authorization.
- I understand that I have the right to inspect or copy the protected health information to be disclosed.
- I understand that information disclosed to any above recipient is no longer protected by federal privacy regulations or other laws and may be subject to re-disclosure by the above recipient.
- I know I may refuse to sign this authorization and that my treatment, payment for my treatment or my enrollment or eligibility for benefits will not be affected.
- I have read and understand this authorization. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records/information upon presentation of a photocopy of this authorization.

_____ _____

Signature of Patient/ Personal Representative Date

_____

Relationship to Patient