Bryan PHYSICIAN NETWORK

Family Medicine of Lincoln
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MESSAGE AUTHORIZATION

Representatives of Family Medicine of Lincoln are allowed to leave information regarding my status as a patient on my voice mail or answering machine. I realize this information may include pertinent health status and/or financial information.

Patient Name: _____ DOB: _____

MRN: _____

❑ **I give permission** to leave information on my voice mail or answer machine

❑ **DO NOT** leave information on my voice mail or answer machine

❑ **DO NOT** speak to anyone about my health status

COMMUNICATION AUTHORIZATION

Family Medicine of Lincoln may communicate information to the following people regarding my health status as needed:

		Type of information			
		All	Scheduling/ Appointments	Medical	Billing/ Insurance
Name: _____	Relationship: _____	☐	☐	☐	☐
Name: _____	Relationship: _____	☐	☐	☐	☐
Name: _____	Relationship: _____	☐	☐	☐	☐

Patient or Authorization Signature: _____ Relationship: _____ Date: _____

This authorization expires upon written notice from me. I understand I have a right to revoke this authorization in writing. The authorization may be revoked in writing delivered to Family Medicine of Lincoln.

The information used or disclosed under this authorization may be subjected to re-disclosure by the recipient and no longer protected by federal privacy laws.

NOTICE OF PRIVACY PRACTICES-PATIENT ACKNOWLEDGMENT OF RECEIPT

I, _____ acknowledge that I received a copy of Family Medicine of Lincoln's Notice of Privacy Practices.

_____ _____ _____
Patient/Representative Signature Relationship Date

Family Medicine of Lincoln is required by law to maintain the privacy of and provide individuals with this notice of our legal duties and Privacy Practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the main clinic phone number.

For Family Medicine of Lincoln Staff Only

Patient, or patient representative did not sign the acknowledgment for the following reason(s):
Check all that apply

- ❑ Refused
- ❑ Refused, stating that he/she has already signed an acknowledgment
- ❑ Unable to sign because of medical condition
- ❑ There was not a patient representative available to sign
- ❑ Other: (explain) _____

_____

_____ _____
Witness Date