Scenic Bluffs
COMMUNITY HEALTH CENTERS

AUTHORIZATION FOR COMMUNICATION OF HEALTH INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), Scenic Bluffs Community Health Center must have your specific authorization to share any of your Protected Health Information (PHI) with a spouse or family member, or to leave a message regarding your health care on your telephone answering machine.

This is especially helpful if you

- are on medications that require frequent testing and adjustment,
- in case there is an urgent need to contact you,
- if we need to reschedule an appointment, test or procedure and you are not available when we call
- if there is someone who assists with your finances,
- if you use a driving service or personal driver who you would like to call to confirm your appointments.

The type of information disclosed could be

- Account/billing information
- Appointment information (dates and times)
- Medical history of diagnostic and therapeutic information, this may include information regarding mental health, developmental disability, HIV, alcohol and drug abuse, unless otherwise specified below.

This form **DOES NOT** authorize the disclosure of any of your written health information. You can choose to limit the health information that is shared with any person or agency that you list.

Verbal Communication regarding my treatment can be shared with (please print):

Name	Relationship	Phone Number	Type of Information
_____	_____	_____	❑ All ❑ Limited to: _____
_____	_____	_____	❑ All ❑ Limited to: _____
_____	_____	_____	❑ All ❑ Limited to: _____

If under 18 years of age, list parent names below:

MOTHER:_____

FATHER:_____

IN CASE OF EMERGENCY…
Name of local friend or relative: _____

Relationship to patient: _____ Phone Number:_____

Please indicate below where we may contact you and leave a message regarding your Medical, Behavioral Health and/or Financial information, if appropriate:
HOME: _____ **CELL:**_____ **WORK:** _____

You may refuse to sign this authorization with the understanding that this may results in a delay of treatment and/or potentially adverse health consequences. By signing this form, you understand that at any time, you may change or revoke this authorization. This authorization will expire in two years from the date signed.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____
(If signed by authorized person, state relationship and authority to do so.)