

HIPAA Authorization for Disclosure of PHI Form



Patient Name: _____ Date of Birth: _____

Please provide the following information:

(The following is an authorization for miscellaneous services this office uses. We will make every effort to abide by your instructions.)

Appointment Reminders/Test Results (laboratory, x-rays, etc.):

If we need to reach you regarding an appointment or test results, we will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours.

Please complete/check all items below that apply to you:

May we call/text/email to remind you of an appointment or regarding test results? Yes No

Please contact me:

Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

If we get an answering machine/voicemail, may we leave a message? Yes No

If we get a family member, may we leave a message? Yes No

I understand I have a right to request communication with UOA, a division of OrthoNJ through email and by doing so I understand that currently their email is not encrypted. I also understand that non-encrypted email can result in possible public access of my personal information. My initials indicated below show I understand and still will like this type of communication to be possible.

Initials: _____ Date: _____

Policy for discussing your medical information with other individuals:

Our office will never discuss your medical information with other individuals unless you have authorized us to do so. Please indicate the individuals authorized to discuss your medical care by checking all items that apply to you and providing the name(s) where applicable.

Spouse _____

Parent(s) _____

Child(ren) _____

Sibling(s) _____

Other(s) _____

Signature: _____ Date: _____