Community Medical PA
520 West Main Street
Marshville, NC 28103
704 624 3388

AUTHORIZATION FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION

It is frequently necessary for personnel at this practice to communicate information such as appointment schedules/rescheduling, lab results, instructions, information about treatment and other items of protected health information with our patients. It is frequently not possible to speak personally with the patient to communicate this information. In the event that our personnel are not able to speak with you (the patient) directly, please give us instructions on communicating with you.

1. Messages may be left on my home answering device at _____

2. My answering device does not identify me by name, but it is appropriate to leave messages for me there. (circle) yes or no

3. Messages may be left on my work voicemail at _____

4. Messages may be left on my cell phone voicemail at _____

5. Messages may be left for my spouse/partner at

   Name of spouse/partner_____

   Spouse/Partner cell phone_____

   Spouse/Partner work/voicemail_____

6. Other person(s) authorized to receive messages on my behalf

   Name_____ Phone_____

   Name_____ Phone_____

   Name_____ Phone_____

7. I also consent to the sharing of my Protected Health Information on HIE sites/platforms to foster collaborative care with other providers.

I hereby release, discharge, and hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time. This consent is valid unless it is otherwise revoked in writing.

_____

Signature of Patient or Parent/Guardian Date

_____

Patient Name (print) Date of Birth