Communications and HIPAA Authorizations

*Completion of this document authorizes the disclosure and/or use of health information about you. The purpose is to give your health care provider permission to communicate in ways and with whom you authorize.*

**Phone Message Authorization**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient name), hereby authorize OKC Neurology-Catherine E Porter MD, PLLC to be able to call the following telephone number(s):

And leave a detailed message/voicemail with the following information.

Patient’s Initials:

\_\_\_\_\_Test and other exam results

\_\_\_\_\_Only the following records or type of health information (including dates)

\_\_\_\_\_Details about my next appointment (physician name, date and time)

\_\_\_\_\_I DECLINE. PLEASE DO NOT LEAVE ANY MESSAGES

**Patient Portal Authorization**

You are entitled to the creation of a personal, secure OKC Neurology patient portal account. By providing us with your personal (non-work) email address and opting into our patient portal services, you acknowledge that we will send a sign up invitation to the

the email address you provide. This form authorizes us to send the invitation and additional communications from OKC Neurology in the future.

I also understand that I must inform OKC Neurology of any changes to my email address as soon as they occur, in order to protect my private patient data. I waive OKC Neurology of any fault related to my own distribution (intended or otherwise) of my personal email or patient portal log in credentials.

\_\_\_\_ YES, I would like to enroll in OKC Neurology’s patient portal service and and authorize OKC Neurology to send communications to my personal email address (if this is your selection, please clearly write your email address below)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(email address)

\_\_\_\_\_ NO, I AM DECLINING enrollment in OKC Neurology’s patient portal service at this time, and may change my preference during my next office visit by requesting to fill out a Communications form.

**Alternative Communication Path Authorization**

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have the right to request that communications concerning your protected health information (PHI) be made by alternative means or at an alternative location(s). We will do our best to accommodate all reasonable requests.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient name) hereby request the following changes be made in the way the office communicates with me regarding my personal health, treatment or payment for treatment:

Description of special communication methods to be used (Please specify alternate telephone numbers, alternate mailing addresses, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start date for alternative communication path(s):

End date for alternative communication path(s):

**Disclosures to Friends and/or Family Members**

I hereby authorize and consent to the release and disclosure of my Protected Health Information for the purpose of communicating results, findings, care decisions and information to the individuals listed below:

Name, Relationship, Contact Number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expiration of Preferences/Authorizations for which dates not explicitly given above:**

Please select option below

Pt initials

\_\_\_\_ 1 year from date of signature below

\_\_\_\_\_ Specific date

**Revocation:**

I may revoke the above authorization at any time – but must do so in writing to the following address: **OKC Neurology-Catherine E Porter MD, PLLC 5500 NW Expressway, Suite E, Warr Acres, OK 73132**. My revocation will take effect upon receipt except to the extent that others have acted in reliance upon this authorization.

**Right of Refusal:**  
I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

**Redisclosure:**

Information disclosed pursuant to this authorization could be redisclosed by recipient(s). Such re-disclosure in some cases is not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name (printed)

Patient signature date/time

Patient’s legal guardian or representative (printed)

Patient’s legal guardian or representative (signature) date/time