ARCHANGEL MICHAEL HEALTH, PA

HIPAA Authorization for Family/Friend Communication

Date:

1. Patient Information

Last Name: **First Name:** **MI:**

Date of Birth:

2. Notice of Privacy Practices Acknowledgment

I have received and/or reviewed a copy of Archangel Michael Health, PA's Notice of Privacy Practices (NPP). I understand that the NPP provides information on how my protected health information (PHI) may be used and disclosed.

Initial here: _____

3. Communication Consent

General Contact & Follow-Up:
I consent to being contacted regarding appointments, test results, and care-related matters.

☐ I consent to general contact and follow-up

Photos/Recordings:
For patient care, documentation, or security purposes.

◯ I consent ◯ I do not consent

Email/Text Communications:
For instructions, reminders, and health education.

◯ I consent ◯ I do not consent

Note: Standard SMS texts may not be encrypted.

4. Authorization to Disclose Health Information to Family/Friends

I authorize Archangel Michael Health, PA to discuss my health information (including scheduling, treatment, payment, and other healthcare operations) with the individuals listed below. This may include information about diagnosis, lab results, billing, medications, and other relevant health matters.

Name	Relationship	Contact Information

Sensitive information (psychiatric, HIV/AIDS, genetic testing) may also be disclosed unless specifically excluded in writing.

I understand that I can revoke or modify this authorization in writing at any time.

5. Information Release & Expiration

Release of Information: By signing, I understand that my health information may be disclosed for treatment, payment, or healthcare operations as detailed in the NPP. This may include sharing with healthcare entities, third-party payers, or information exchanges.

Expiration: This authorization remains valid until I revoke it in writing or until:

Date: or **Event:**

If no date/event specified, this authorization remains in effect until revoked.

6. Prescription Pick-Up Authorization (Optional)

I authorize the following individual(s) to pick up prescriptions on my behalf:

Name: **Relationship:**

Name: **Relationship:**

☐ I do not authorize anyone else to pick up prescriptions

7. Patient Signature

I have reviewed and understand this HIPAA Authorization for Family/Friend Communication. I voluntarily sign this form and acknowledge that I understand the contents.

Patient/Legal Representative Signature:

Date: **Printed Name:**

Relationship to Patient (if not self):

Please attach legal documentation if you are the patient's guardian, Power of Attorney, or other representative.

Office Use Only

Date Received: **Staff/Privacy Officer Signature:**

☐ Photocopy/scanned copy placed in patient file

Thank you for trusting Archangel Michael Health, PA with your healthcare needs.

Questions? Phone: (352) 441-9110 | Secure Fax: (352) 441-9114 | Secure Email: manager@archangelmichaelhealth.com

A photocopy or fax of this signed form is considered as valid as the original.