Release of Medical Information Consent Form

Patient Name: _____DOB:_____

By filling out the information below we will better be able to serve you. If you allow us to leave a message and/or to speak with a trusted individual regarding your medical care we need written authorization in order to do so.

Please indicate if we have your permission or not to leave phone messages regarding your medical care:

___I authorize Painted Rock Family Medicine to leave phone messages containing my Personal Health Information on the following telephone number(s):

_____

__ No I do not authorize Painted Rock Family Medicine to leave phone messages regarding my Personal Health information on any of my telephone numbers

__ I authorize the verbal release of my Protected/Personal Health Information to the person(s) listed below at my request. These individuals are family and/or trusted friends. Painted Rock Family Medicine has my permission to share my medical care and treatment information, test results, and billing matters with their verbal request (not including sensitive health information). You also have my persmission to leave a telephone message directly with the person(s) and telephone numbers listed below. I understand that by leaving this section blank, It indicates that I do not grant permission for Painted Rock Family Medicine to speak with a family and/or trusted friend.

Name:_____Relationship:_____Phone #:_____
Name:_____Relationship:_____Phone #:_____
Name:_____Relationship:_____Phone #:_____
Name:_____Relationship:_____Phone #:_____

I understand I have the right to revoke authorization at any time. I understand if I revoke this authorization I must do so in writing and present the written revocation to the employees at Painted Rock Family Medicine. I understand revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with right to contest a claim under my policy. I understand that I may not be denied treatment or payment for health care services if I do not sign this form.

I release Painted Rock Family Medicine from any and all liability and claims of any nature pertaining to the disclosure of requested information once a disclosure takes place.

Patient Signature:_____ Date:_____

Witness: _____

If patient is unable to sign, Please document reason: