United Family Medicine
A COMMUNITY CLINIC

Authorization to Discuss Protected Health Information

Patient's Legal Name _____ (office use only: MRN _____)

Previous Names _____ Birth Date ___/___/___

1. **Phone Messages**

My care team may leave information on my voicemail or answering machine at these numbers:

Home _____ Cell: _____ Work: _____

Please share: ☐ Scheduling information ☐ Medical information ☐ Billing information ☐ Nothing

2. **Person-to-Person Communication**

To help with my care or billing, my care team may share information with these people:

_____	_____	_____
First name, Last name	*Relationship to me*	*Best Contact Number*
_____	_____	_____
First name, Last name	*Relationship to me*	*Best Contact Number*
_____	_____	_____
First name, Last name	*Relationship to me*	*Best Contact Number*

Please share: ☐ Scheduling information ☐ Medical information ☐ Billing information ☐ Nothing

I understand the following:

- This consent applies to United Family Medicine using UFM's shared electronic medical record.
- My care team will release all details to the person or persons named above. This includes details about treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV. If I don't want this information shared, I will write my initials here: _____.
- **This form is good for one year**. If I want to change the information on this form, I will fill out a new form. If I want to add or remove people for person-to-person communication, I will fill out another form.
- Once my information is shared with the person or persons named above, it may no longer be protected by privacy laws. United Family Medicine cannot prevent these persons from sharing my information with a third party.
- If I do not sign this form, I will still be treated.

_____	_____	_____
Date/Time	*Signature of patient or Authorized Person*	*Authorized person's authority to sign (proof required)*

Reason patient is unable to sign: ☐ Minor ☐ Other: _____

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