Catholic Health
Physician Partners

Patient Name_____ Patient DOB_____

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations Catholic Health Physician Partners may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit Catholic Health Physician Partners to disclose my protected health information for the purposes of appointment, test, procedure, reminders and follow-ups to the following individuals:

_____ _____ _____

Name Relationship to me Phone #

_____ _____ _____

Name Relationship to me Phone#

I expressly permit Catholic Health Physician Partners to disclose my protected health information for the purposes of appointment, test, procedure, reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine: Tel.#_____

Office voicemail: Tel. #_____

Other (specify)_____ Tel #_____

_____ _____ _____

Signature of Patient Printed Name Date

Personal Representative

Parent/Guardian