Concord Children's Clinic

Authorization for Release of PHI

Patient Name: _____ Date of Birth: _____

Concord Children's Clinic is authorized to release Protected Health Information (PHI) regarding the above-named patient to the entities named below. Your PHI includes general health information, laboratory tests and billing information. The purpose is to inform the patient or others in keeping with the patient's instructions.

How would you prefer that we communicate your PHI if you cannot be reached directly?

Please answer the following questions by marking YES or NO

- Is it ok to leave detailed messages on your home answering machine? YES ◯ NO ◯
  If YES, please provide phone number: _____
- Is it ok to leave detailed messages on your work voice mail? YES ◯ NO ◯
  If YES, please provide phone number: _____
- Do you want us to contact you by cell phone and/or leave detailed messages on your cell phone voice mail? YES ◯ NO ◯
  If YES, please provide phone number: _____

- Is it ok to leave detailed messages with anyone other than yourself? YES ◯ NO ◯
  Examples would include, but are not limited to spouse, domestic partner, adult children, parents (if you are over 18). Please provide name(s) and phone number(s) of these individuals below:

_____ Print Name/ Phone Number

_____ Print Name/ Phone Number

_____ Print Name/ Phone Number

_____ Print Name/ Phone Number

Patient Information

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

I have reviewed and I understand this form. Please sign below.

Signature of Patient: _____

Date: _____