PRIMECARE MEDICAL GROUP

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Do We Have Permission To:

Leave test results or appointment confirmations on your		
Answering machine at home?	YES	NO
Leave a message at your place of employment	YES	NO
Leave a message, test results, or appointment confirmations	YES	NO
On your cell phone voice mail?		
Fax copies of your results to another physician if necessary?	YES	NO
Call or text you with a reminder of your appointment or to request a survey?	YES	NO

I hereby authorize all medical service sources and health care providers to use and/or disclose my protected health information (PHI)
I hereby authorize the release of my PHI as follows (check one):

_____My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse.

_____My complete health record (with the exception of the following information):

_____ Mental Health Records
_____ Communicable diseases (including HIV and AIDS)
_____ Alcohol/drug abuse treatment
_____ Other (please specify)

In addition to the authorization of my personal health information, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

NAME:_____Relationship_____

NAME:_____Relationship_____

NAME:_____Relationship_____

I allow PrimeCare Medical Group to view my prescription history from an external source

_____Initial here

Self Paid (non-insured) Patients Only

I certify that I do not have insurance benefits and that I will not be filing to an insurance company for reimbursement of these charges.

_____Initial here

Insured Patients Only

I authorize payment of medical benefits to Prime Care Medical Group. I understand that I may be responsible for any amount not paid by my insurance company if they are deemed non-covered items.

_____Initial here

_____ _____

Signature of Patient **Date**

_____ _____

Print Name **Relationship to Patient**

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