

Authorization to Release Protected Health Information (PHI)



belmontcambridgehealthcare.com
617-491-5111 | fax 617-491-5222

Patient information

Last name: _____

First name: _____ MI: _____

Date of birth: _____

I understand that I am classified as a legal adult under the law. This means that my parents and/or legal guardians may NOT access my health information, under the HIPAA Patient Privacy Acts. In full knowledge of my rights to privacy, I am WAIVING my right to privacy to the following individual(s):

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

I consent for the following to be discussed with him/her/them (check all that apply):

- Confidential laboratory/radiology results
- Scheduling and cancelling of appointments
- Prescription Information (name and indication of prescription, dosing, refills, etc.)
- Health history
- Recent health problems
- Other: _____

Consent for telephone contact

I understand that the office will be contacting me at home or the number of my choosing to confirm appointments.

Phone: _____ Preferred
 Home Office Cell Other

Phone: _____ Preferred
 Home Office Cell Other

Phone: _____ Preferred
 Home Office Cell Other

In addition, I consent for the office to (check all that apply):

- Leave a message to report the results of lab test
- Leave other messages

Consent for correspondence by mail

I understand that the office will be sending me correspondence by mail. In addition, I consent for the office to send (check all that apply):

- Reminder post cards for annual physical appointments
- Laboratory test results
- All other correspondence from our office by mail

Signature

NOTE: If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign and fill in the information below.

Parent/Guardian name: _____

Relationship to patient: _____

Signature: _____

Date: _____