LaPine Community HEALTH CENTER

Disclosure of Protected Health Information (PHI)
(HIPAA Form)

Patient Name (please print): _____ DOB: _____ Date: _____

La Pine Community Health Center may: (*check all that apply*)			
*Leave **medical** information on voicemail:*	□ Cell Phone	□ Home Phone	□ None
*Leave **billing** information on voicemail:*	□ Cell Phone	□ Home Phone	□ None
Use for automated appointment reminders or general messages:	□ Cell Phone	□ Home Phone	□ None

If there is anyone that you would like to give us permission to speak with regarding your healthcare, please indicate below:

I authorize La Pine Community Health Center to speak to the following people, in person or by telephone:

1. Name: _____Relationship: _____ Phone: _____
   Regarding: □ Schedule or cancel appointments □ **All** information
   □ Other: (please specify) _____
2. Name: _____Relationship: _____ Phone: _____
   Regarding: □ Schedule or cancel appointments □ **All** information
   □ Other: (please specify) _____

Please list legal representative, guardian, power of attorney, etc., if any: (*must provide proof)*

1. Name: _____Relationship: _____ Phone: _____
2. Name: _____Relationship: _____ Phone: _____

Patient Signature: _____ **Date**: _____