CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

Name (First, Middle , Last)		**Date of birth**
Previous Name	**Cell Phone Number / Home Phone Number** /	

CONSENT TO LEAVE MESSAGES

MYSELF: I give permission to leave my personal health information such as test results and appointment information on my:
____ Answering machine ____Voicemail

CONSENT FOR VERBAL DISCLOSURE TO FAMILY/FRIENDS

Under the requirements of HIPAA, Myrtue Medical Center is allowed to disclose medical information upon consent. The name(s) below are family members or friends to whom I grant permission for my Provider or my Provider's staff members to verbally discuss information about me. **NOTE: This designation does not give the named individuals the right to make health care decisions for you**.

Name	Relationship	Phone Number

FAMILY / FRIENDS: I give permission to leave my personal health information such as test results and appointment information on the above listed family or friends:
____ Answering machine ____Voicemail ____Cell phone #______________________________

Applicable Timeframe and Revocation
This consent for disclosure will remain in effect for 3 years or until revoked by myself or my personal representative. I have the right to change or revoke my permission in writing at any time. I understand I must complete a new form or notify Myrtue Medical Center in writing if I want to change or revoke any of the consents indicated above.

Patient Signature: ____ Date: ____________________

(Patient Representative/Parent): ____ Date: ____________________

Internal Use Only:

MR#	**Account#**	**Date Accepted:**	**Initials:**