PINNACLE FAMILY PRACTICE

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Authorization for Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____

I authorize the use / disclosure of health information about me as described below:

A. Person(s) or Organizations authorized to receive the information:
   ( ) Spouse:_____
   ( ) Parent(s):_____
   ( ) Family Members_____
   ( ) Other:_____

B. I authorize the health care team (doctors and staff) to communicate my exam/test results in one or more of the following ways:
   May leave a Message to "return our call" on voicemail or text:
   ( ) cell phone ( ) home phone ( ) work phone
   May leave a Message to return our call with another person:
   ( ) at home ( ) at work
   May leave a message reminding you of an upcoming appointment with instructions:
   ( ) cell phone ( ) home phone ( ) work phone
   ( ) cell phone by text message (standard text message fees may apply)- will be available in the future
   May leave a detailed message with type of test and those test results on voicemail:
   ( ) home phone ( ) cell phone ( ) work phone

C. I understand that this authorization pertains to all health information and billing information
D. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at anytime by notifying Pinnacle Family Practice, LLC **in writing**
E. I understand that I can refuse to sign this authorization form and that my refusal will not affect my ability to obtain treatment, payment or eligibility for benefits (if applicable). However, the staff at Pinnacle Family Practice, LLC would thus be unable to leave any messages of any nature, and you would be required to call or come in for results.
F. I understand that this authorization will expire 1 year from today's date

Patient Signature:_____ Date:_____
Witness:_____