PEDIATRIC ASSOCIATES
OF MT. CARMEL, INC.

Patient _____

Date of Birth _____

COMMUNICATION RELEASE OF INFORMATION

The Privacy Rule generally requires healthcare providers to take reasonable steps to minimize the Protected Health Information (PHI) requests, usage, and disclosure for only what is required to meet the intended need. There provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

NOTE: Uses and disclosures for reasons other than treatment, payment, or operations may be permitted without prior consent in a medical emergency.

☐ DO NOT PROVIDE health information (regarding appointments, medication, and test results) or account information to anyone but me.

☐ I give permission to receive my health information regarding normal test results in a voice mail message.

Authorized Representatives

I give permission for the following people to receive the following PHI elements as specified below:

Name _____ Relationship _____ Phone # _____

☐ Appointments ☐ Billing ☐ Test Results ☐ Discuss my condition and treatment

Name _____ Relationship _____ Phone # _____

☐ Appointments ☐ Billing ☐ Test Results ☐ Discuss my condition and treatment

Name _____ Relationship _____ Phone # _____

☐ Appointments ☐ Billing ☐ Test Results ☐ Discuss my condition and treatment

Name _____ Relationship _____ Phone # _____

☐ Appointments ☐ Billing ☐ Test Results ☐ Discuss my condition and treatment

I acknowledge I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted in writing to the Practice Manager/Privacy Officer, Jasmine Sandhu

My signature below acknowledges that I have provided the information above:

Signature of Patient _____ Date _____

THIS FORM CAN BE FAXED TO 513-752-3387 IF COMPLETED OUTSIDE OF THE OFFICE