HIPAA COMMUNICATION RESOURCE TOOL OF PROTECTED HEALTH INFORMATION
OZARKS FAMILY HEALTH LLC PRIVACY NOTICE

I, _____, with a date of birth of _____ hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below:

Family member or person authorized to receive <u>verbal</u> information for the above named patient's care:

_____	_____	_____
Name of Central Contact (other than patient)	Relationship to Patient	Phone

Others authorized to receive my <u>verbal</u> information (please list names and relationship):

_____	_____	_____
Print Name	Relationship to Patient	Phone
_____	_____	_____
Print Name	Relationship to Patient	Phone

+ Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations.

• Do you wish to be a confidential or non-published patient for directory status? ☐ Yes ☐ No
(Example: If you are in our clinic seeking treatment and a spouse or other family member calls to inquire if you are still there, can we say yes or no?)

• Leave message on answering machine? ☐ Yes ☐ No
(Example: We may leave message reminders, scheduling changes or notices that lab results are in on your answering machine. Would this process be acceptable, yes or no?)

+ Leave message for patient to return call? ☐ Yes ☐ No
(Example: We may leave a message regarding appointment reminders, scheduling changes or notices that lab results are in with an individual who answers the phone. Would this process be acceptable, yes or no?)

• Acknowledgement Statement:
I have been offered a copy of the Notice of Privacy Practices and *received* a copy or ☐
I have been offered a copy of the Notice of Privacy Practices and *declined* a copy ☐

Patient or Legal Personal Representative:_____ Date:_____

Patient or Legal Personal Representative: _____ Relationship to Patient:_____
(PRINTED NAME)

Note: Except to the extent that action has already been taken in reliance on this PHI Communication Resource Tool, at any time I can revoke this PHI Communication Resource Tool by submitting a notice in writing to the Clinic Manager.

Patient Name: _____