Authorization to Communicate and Leave Telephone Messages

MidMichigan Health

MidMichigan Health is committed to safeguarding your protected health information. To communicate verbally with another individual of your choosing, or to receive a telephone message regarding an appointment reminder, test results, follow-up appointments, or other important messages from your providers we are asking for your written permission. Please mark the appropriate boxes below:

☐ I authorize MidMichigan Health to **discuss** with: ____ ,

____

who is my ______________________________________ and is involved in my care, any relevant information about my care and treatment. I understand that this may include confidential personal health information. (This does not allow for printed copies or electronic access to my protected health information)

☐ I authorize MidMichigan Health to leave telephone messages at my **HOME** or on my answering machine or voicemail. I understand that the message may include confidential personal health information. (This does not allow for printed copies or electronic access to my protected health information)

Phone Number: ______________________

☐ I authorize MidMichigan Health to leave telephone messages on my **WORK** answering machine or voicemail. I understand that the telephone message may include confidential personal health information. (This does not allow for printed copies or electronic access to my protected health information)

Phone Number: _______________________

☐ I authorize MidMichigan Health to leave telephone messages on my **CELL** answering machine or voicemail. I understand that the telephone message may include confidential personal health information. (This does not allow for printed copies or electronic access to my protected health information)

Phone Number: _______________________

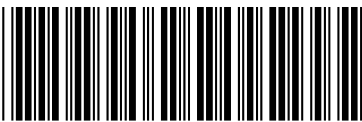
I hereby grant the above elected methods of communication about my protected health information. Furthermore, I understand that I may at any time change or rescind my elections either by completing a new form, or by written correspondence with this office; otherwise, this election is valid for 12 months.

____ ____________________________

Patient Name (print) DOB

____ ____________________________

Patient/Parent/Legal Guardian Signature Effective Date/Time



Authorization for Disclosure