



Release of Protected Health Information

Patient Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medical Record No. \_\_\_\_\_

Please identify the person or persons you authorize your Protected Health Information to be released to for treatment and payment purposes by Plaza Medical Group. Your authorization means that Plaza Medical Group can discuss your health information in person or over the phone with these individuals to assist with your treatment, to inquire about payment and insurance coverage, and related matters. The information disclosed to these individuals may indicate the presence of a communicable or non-communicable disease.

This may include your spouse, parents, siblings, children, friend or guardian. Please list below:

Table with 2 columns: Name, Relationship. Multiple empty rows for listing individuals.

In addition, we request your permission to leave phone and voicemail messages regarding your Protected Health Information (test results, instructions, reminders regarding type of appointment etc.).

Please check the appropriate boxes:

[ ] Yes, I authorize Plaza Medical Group to leave messages on my answering machine/voice mail regarding my Protected Health Information.

[ ] No, I do not authorize Plaza Medical Group to leave messages on my answering machine/voice mail regarding my Protected Health Information.

If changes in your situation occur please notify us otherwise this form will remain in effect for three (3) years.

Signature of Patient or Legal Representative

Date

Description of Legal Representative's Authority