

**PERMISSION TO COMMUNICATE PROTECTED HEALTH INFORMATION**

- 1. I Grant permission to Exempla Surgical Specialists to disclose health information of the following individual as specified below:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- 2. I authorize the information to be disclosed as specified below:**

- On my voicemail/answering machine at **home** \_\_\_\_\_ (specify phone #)
- On my voicemail/answering machine at **work** \_\_\_\_\_ (specify phone #)
- On my voicemail on my **cell** \_\_\_\_\_ (specify phone #)
- To the following member(s) or other person(s):

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name Relationship Phone Number

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name Relationship Phone Number

- Other: **(not able to email results/information)** \_\_\_\_\_

- 3. The type and amount of information to be disclosed is as follows: (Please check appropriate boxes)**

- Laboratory results  Medical instructions or advice
- X-Ray reports
- Prescription drug information
- Appointment information, including confirmation/cancelation of appointment and type of appointment.
- Do not leave any information on voicemail, attempt to contact directly

\*I understand that this may include detailed personal medical information including medical services to be provided, notification that items such as refills are ready for pick-up, as well as any information listed in #3 above.

\_\_\_\_\_  
Signature of Patient or Authorized Person Representative  
(Please attach applicable legal documentation of authority)

\_\_\_\_\_  
Date

*This consent form will expire when revoked in writing by the patient/representative or in the case of a minor, on the date the minor becomes an adult under state law, whichever occurs first.*