☐ Documented in EMR

Multicare Associates

Authorization to Discuss Protected Health Information

Patient's Legal Name (Print) _____
First Name MI Last Name

Previous name(s)_____ Birth date _____/____/_____

You may use this form to allow your healthcare providers to disclose, access, and use your health information from services provided.

1. Phone Messages

My care team may leave information on my voicemail or answering machine at these numbers:

Home:_____Cell:_____ Work:_____

2. Person-to-Person Communication

To help with my care or billing, my care team may share information with these people:

First name, last name	Relationship to me	Best contact number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand the following:

- This consent applies to Multicare Associates clinics using Multicare Associates shared electronic medical record.
- This form does not expire. If I want to change the information on this form, I will fill out a new form.
- Once information is shared, Multicare Associates cannot prevent it from being shared with a third party. At that point, it may no longer be protected by privacy laws.
- If I do not sign this form, I will still be treated.

_____ _____ _____

Date *Signature of patient or authorized person* *Authorized person's authority to sign (proof required)*

Reason patient is unable to sign: ☐ Minor ☐ Other:_____