CLINIC AUTHORIZATION - Patient Designated Recipients of Health Care Information

MRN# ____________________________________

Patient Name ____________________________________

Copy given to requestor (Date) ________________

THIS FORM MUST BE COMPLETED IN FULL

WAKE FOREST BAPTIST HEALTH

For a list of entities covered by this form please see www.wakehealth.edu/compliance/Notice-of-Privacy-Practices.htm.

AUTHORIZATION *for* USE *or VERBAL* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

I. I consent to and authorize: WAKE FOREST BAPTIST HEALTH, to release to:

Name	A or R	Relation to patient	Phone # (xxx) xxx-xxxx	Address (include Zip Code)

II. A/R: Description of information that may be used/disclosed to persons listed above: Select ONE per name above

A Verbally share all information.* (However, may release: hard copies of labs and other ancillary test results for treatment purposes; allow prescription and form pick-up and provide copies of claims, billing statements, etc.) (*Does not apply to the release of medical records.*) * ***(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)***

R **RX** only– Name(s) of persons only authorized to pick up prescriptions and forms. (*Does not apply to the release of medical records.*)

III. The information will be used/disclosed for the following purposes:

☐ At the request of the individual (s) -OR-

☐ Treatment, scheduling, coordination of services, and other ____.

IV. I authorize WFBH to leave voice mail messages on my voice mail.
☐ Yes ☐ No, Leave appointment reminders only.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.

I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the WFBH Privacy Office. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Information about the right to revoke has been shared with me in the WFBH Notice of Privacy Practices.

This authorization expires 5 years from the date signed unless revoked as explained above.

_______________________________________ Signature of Patient or Personal Representative (*if applicable*)

_______________________________ Patient's Date of Birth

_______________________________________ Relationship to Patient

_______________/_______________ Requestor's Home Phone/Work Phone

_______________________________________ Authority to Act

_______________________________ Date/Time (Required)

To obtain copies of Medical Records, a separate authorization is required.
Please contact the appropriate WFBH Department or
WFBH Health Information Management Medical Records Department at (336) 716-3230.

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Instructions:

Section I:

If you want WFBH clinics to only provide information to you directly, write **"NONE"** in Section I and **"NA"** in Section III. Go to Section IV to complete this form.

- **Name:** In the spaces provided please enter the names of the persons you authorize to request and receive information about your care in the WFBH clinics. This includes communication in person, by fax, or by telephone.
- **A or R:** Enter **"A"** beside the name(s) of the persons who can request and receive **all** information concerning your care.
  - *** R:** Enter **"R"** beside the name(s) of the persons **who can only pick up prescriptions or other completed forms on your behalf**. These persons cannot receive any other information about your care in the WFBH clinics.
- **Relation to Patient:** Examples of entries: Spouse, friend, daughter, son, mother, etc.
- **Phone #:** Enter contact phone # for the person you authorize
- **Address:** Enter physical address, -----no P.O Boxes, Please.

Section II: For Patient Reference- No Information Requested.
Descriptions of Information that can be exchanged with the persons authorized with the "A" or "R"

Section III: Check (✓) **'At the request of the individual'** if you want the person(s) listed above to receive information anytime they request information.
Check (✓)'**Treatment, scheduling, coordination of services and fill in the blank'** if you wish to limit the information received to these situations.

Section IV: Check (✓) **Yes** if you authorize
WFBH to leave phone messages on your answering machine regarding such things as appointments, directions, normal test results, medication changes information confirmations for address, insurance etc.
Check (✓) **No** if you **do not** want WFBH to leave phone messages other than appointment reminders.

Signature Required for Authorization

- ☐ The person completing the form should sign the form.
- ☐ Provide *patient date of birth---* **(month/day/year)**
- ☐ If the patient completes the form, enter 'Patient' in the *Relationship to Patient* field.
  - If someone other than patient completes form, enter that person's relationship to patient.
- ☐ Enter Requestor's Phone Numbers. **Home/Work: (xxx)xxx-xxxx / (xxx)-xxxx.**
  - The **Requestor** is either **the patient** or **the Personal Representative with the Authority to Act**.
- ☐ **Authority to Act:** ***For Legal Personal Representatives Only***.
  If you are the legal personal representative for the patient, please enter "Legal guardian", "Power of Healthcare Attorney", "Power of Attorney", etc.
- ☐ **Date:** Enter the date the form was completed and signed **(Month/Day/Year)**

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