PHI Communication Form

IMPORTANT: This form does not give the authorized person(s) referenced below the permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record.

Patient Identification

Printed Name:_____ Date of Birth:_____

Address:_____ Last 4 digits of SSN:_____

_____ Telephone:_____

I,_____, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below.

Authorized person(s) to receive **verbal** information regarding the above patient's care:

Printed Name	Relationship to Patient	Telephone
Printed Name	Relationship to Patient	Telephone
Printed Name	Relationship to Patient	Telephone

Mercy will not release paper or electronic copies of your medical record to anyone including those listed above unless an ***Authorization for Use and Disclosure of Protected Health Information or Patient's Request to Access Protected Health Information*** form is completed, or Mercy is already permitted by law to do so.

Mercy may still speak to other persons not listed on this form about your care if otherwise permitted by law.

I understand I may revoke this authorization at any time and Mercy will cease discussing my Protected Health Information with the above person(s) upon receipt, unless otherwise relied upon or if Mercy is not otherwise required by law to share information with the above person(s).

Patient or Legal Personal Representative:_____ Date:_____
Signature

Patient or Legal Personal Representative:_____
Printed Name

Authority of Personal Representative:_____

Patient Name:
MRN#:
Date of Birth:

Mercy