

Highlands Family Medicine

Consent to Disclose Personal Health Information

Help us communicate with you better!

Please use this form to tell us when you would like us to leave messages or discuss your health with others, and how we should contact you with non-urgent news such as lab results or appointment reminders.

Patients' full legal name _____

Date of birth _____

1. What name would you prefer to be called _____

2. When is it okay to leave a message about your health – please mark all that apply:

Never _____

On home voicemail Number _____

On work voicemail Number _____

On mobile voicemail Number _____

3. Who is it okay to discuss your health with:

No one _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

4. What is okay to discuss or leave a message about? This may include detailed personal information, including medical services to be provided, refills, etc.

Any/all information _____ **OR**

Lab results _____ Medical instructions/advice _____ x-ray reports _____

Prescription drug information _____ Appointment information _____ Other (specify) _____

Printed Patient Name

Date

Signature of patient or authorized personal representative

This consent will remain in effect until revoked by the patient/representative, or in the case of a minor, on the date the minor becomes an adult under the state law. Please advise us of changes.

This form does not apply to behavioral health information.