PALOUSE PULMONOLOGY & SLEEP MEDICINE

PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

Authorization to Disclose Information to Family Members/Friends

I, the undersigned, authorize Palouse Pulmonology & Sleep Medicine to disclose all of my medical information to the following individuals:

Spouse: YES NO Name:_____ DOB:_____
Children YES NO Name:_____ DOB: _____

YES NO Name:_____DOB: _____
YES NO Name:_____DOB: _____
Other YES NO Name:_____DOB: _____

HIPAA Message Authorization

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that apply):

_____ Home Telephone
_____ Cellphone number
_____ Okay to leave a message with detailed info
_____ Okay to mail to my home address
_____ Leave a message with a call-back number only
_____ Okay to mail to my work address
_____ Okay to fax to this number:_____
_____ Work Telephone
_____ Leave a message with a call-back number only

Patient/Guardian Signature

_____

Date _____

Name (Printed)_____Date of Birth___/___/_____

FOR OFFICE USE ONLY:

Written acknowledgment of receipt of our Notice of Privacy Practices but could not, due to:

____Individual refused to sign this document
____Care provided was emergent
____Other:_____

Employee Name:_____Date: _____