Frost Family Medicine

MRN: _____

Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must give us an alternative address or other method of contacting you. ***Some method of contact must be provided.***

We will not ask why you are making your request, and will make efforts to accommodate all reasonable requests.

This request supersedes any prior request for communication of information I may have made.

Extended Authorization

Please list any persons you would like to have access to your billing, appointment or health information (with the exclusion of information that is protected under State and Federal law), such as your spouse, caretaker or other family member:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Restrictions on Communication Methods

Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail. Please indicate below any ways in which you do **NOT** want to receive communications:

- ❑ No restrictions
- ❑ No calls to phone number(s): _____
- ❑ No messages or voice mails left on phone number(s): _____
- ❑ No mail to the following address(es): _____
- ❑ Other (please specify): _____

_____	_____
Signature of Patient /Responsible Party	Date
_____	_____
Name of Patient/Responsible Party (please print)	Relationship to Patient