St.Vincent

PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION

*This form will allow us to leave a message on voicemail or with individuals involved in your health care

PATIENT INFORMATION:

Name of Patient:	**Phone Number:** **Other Number:**
Date of Birth:	**Address:**
Provider/Office Name:	**Office Location/Address:**

I (the undersigned) hereby consent to St.Vincent Health leaving a voicemail message at the number(s) indicated above and /or discussing with the individual(s) listed below information related to my protected health information (PHI). These communications may include, but are not limited to, appointment reminders, medications, pre-registration, billing and insurance items, and any information pertaining to clinical health services, such as laboratory and test results. I understand that this consent is only valid at the office location listed above.

With my consent, St.Vincent Health may discuss my PHI with the following individuals:

Name:	Date of Birth:
Relationship:	Phone #:
Name:	Date of Birth:
Relationship:	Phone #:
Name:	Date of Birth:
Relationship	Phone #:

I understand the information listed above may be communicated via: fax, photocopy, verbal communication, telephone, voice mail and/or direct mail.

If certain information is NOT to be included, please list:_____

YOUR RIGHTS WITH RESPECT TO THIS CONSENT:

I understand that I have the right to revoke this consent at any time by sending a written statement to the St.Vincent Health office location above, except to the extent St.Vincent Health has already made a disclosure in reliance upon my prior consent. Unless revoked, this consent is valid until the expiration date listed below. A photocopy of a signed consent is acceptable, provided that it is apparent that the consent was signed and dated prior to photocopying.

I further understand that this consent does not permit the release of my actual medical records to the individual(s) listed above. Such release will only be made if I sign a separate valid authorization.

If I fail to specify an expiration date, event or condition, this consent will be valid for one year. _____

Expiration Date / Event / Condition

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

(If signed by Legal Representative, state relationship and authority to do so) Signature of Witness

Patient is: ❑ **Minor** ❑ **Incompetent** ❑ **Disabled** ❑ **Deceased**

Legal Authority: ❑ **Custodial Parent** ❑ **Legal Guardian** ❑ **Executor of Estate of Deceased**

❑ **Authorized Legal Representative** **Received by:**_____ **Date:**_____