Health Ministries Clinic
COMMUNITY HEALTH CENTER

COMMUNICATION AUTHORIZATION

I authorize Health Ministries Clinic to share my personal health information with the person(s) below. I understand this authorization is voluntary. I understand that once my information is disclosed, it may be disclosed by the recipient, and the information may not be protected by Federal privacy laws or regulations. I understand this consent will remain in effect until I cancel it in writing.

Patient Name:	**DOB:**

☐ Communicate with Self Only If you are not available, may we leave you a voice message? ☐ Yes ☐ No

If you are not available, who may we communicate with? (Check all that apply)

NAME:	RELATIONSHIP:	PHONE:				
			☐ Health Info	☐ Billing	☐ Scheduling	☐ All
			☐ Health Info	☐ Billing	☐ Scheduling	☐ All
			☐ Health Info	☐ Billing	☐ Scheduling	☐ All

Patient or Legal Representative Signature **Relationship to Patient** **Date**

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