Health Ministries Clinic
COMMUNITY HEALTH CENTER

Patient Communication Authorization

Patient Name: ____ DOB: ______/_____/________

I authorize Health Ministries Clinic (HMC) to share my personal health information with the listed representative(s) below. I understand this authorization is voluntary. I understand that once information is disclosed, it may be disclosed by the third party(s), and the information may not be protected by Federal Privacy Laws or Regulations. I understand this consent will remain in effect until I request an update. This Authorization is for use, pursuant to the HIPPA Privacy Rules, if you are authorizing the release of medical/health information to another individual for access on an on-going basis to assist with your care and maintaining your information. You understand these records may contain information created by other persons or entities, including physicians and other health care providers as well as information regarding **the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (excluding psychotherapy notes), reproductive health services, and treatment for sexually transmitted diseases.** You have the right to revoke this authorization at any time in person at HMC. The revocation is only effective after it is received and logged. Any use or disclosure made prior to a revocation is not included as part of the revocation. The purpose of this form is for HMC to communicate the patient's healthcare information to a 3rd party listed below. **This form expires one year from the date of signature unless revoked beforehand.**

IF YOU ARE NOT AVAILABLE, MAY WE LEAVE A VOICE MESSAGE?

☐ No, do not leave a voice message ☐ Yes, please leave a voice message

IF YOU ARE NOT AVAILABLE, WHO MAY WE COMMUNICATE WITH? **PLEASE CHECK ALL THAT APPLY.**

☐ **Communicate with SELF ONLY**

☐ Name: ____ Phone: (_______) _______-__________
Relationship to Patient: _____________________

☐ Any Information ☐ Appointment Information ☐ Consent to treat minor patient* (For patients under the age of 18)
☐ Emergency Contact ☐ Test Results
☐ Billing Information ☐ Pharmacy

☐ Name: ____ Phone: (_______) _______-__________
Relationship to Patient: _____________________

☐ Any Information ☐ Appointment Information ☐ Consent to treat minor patient* (For patients under the age of 18)
☐ Emergency Contact ☐ Test Results
☐ Billing Information ☐ Pharmacy

☐ Name: ____ Phone: (_______) _______-__________
Relationship to Patient: _____________________

☐ Any Information ☐ Appointment Information ☐ Consent to treat minor patient* (For patients under the age of 18)
☐ Emergency Contact ☐ Test Results
☐ Billing Information ☐ Pharmacy

*By selecting consent to treat, I, as the parent or guardian** of the minor aged patient agree to allow the following persons checked above to give consent to the treatment of said minor.
**Legal guardians please bring your paperwork noting your relation to the minor, if applicable

____ ______/_____/_______
Patient or Parent/Guardian Name Printed **Date**

____
Patient or Parent/Guardian Signature