HIPAA Disclosure Authorization Form

I, ___________________________________, hereby authorize Grandview Family Medicine to disclose
(Please Print)
protected health information about me as described below.

1. The following person or class of persons may receive the disclosure of protected health information.

   Name(s): ______________________________ Relationship: __________________

   ______________________________ __________________

   ______________________________ __________________

2. Specific information to be disclosed is: (*if blank, complete record will be disclosed*)

   All Records______ Vaccines______ Office Notes______ Lab Results______ Rx Pick Up ______

3. I understand that if the person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.

Consent to Leave Voicemail Results

Grandview Family Medicine staff may contact you by telephone with information that may include, but is not limited to, demographic information (full name, date of birth etc), billing information and medical information (diagnosis, medications, test results etc.) Please mark your preference below:

☐ Home Phone____________________________ ☐ Cell Phone ____________________________

☐ Work Phone_____________________________ ☐ Do not leave any information on any number

I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to Grandview Family Medicine. If I do revoke this authorization my revocation will not affect any prior actions taken in reliance on my authorization.

I certify that I have read and understand this authorization and approve of these communication preferences.

___________________________________ __________________ _________________
Signature of Patient or Patient's Representative Patient's Date of Birth Date