PERMISSION TO SHARE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

There are times when others involved in your care would like to discuss your care with Community Health Center, Inc. (CHC). This form grants us permission to speak with those individuals. **You must fill out one of these forms for each person/ organization with whom you give us permission to share. You may revoke this permission at any time by notifying CHC in writing.**

I give CHC permission to share information about my healthcare with the person/organization listed and to the extent indicated below. This permission will be effective until I revoke it in writing.

Print Name of Person/Organization	Address	Contact Phone #	Relationship

Type(s) of information CHC is authorized to disclose **(check <u>all</u> that apply)**:

Appointment Scheduling & Verification	☐	Forms/Records (picking up, questions on)	☐
Billing Questions/Insurance Coverage	☐	Medications – Refills/Dosage/Usage	☐
Care/Care Plan/Treatment	☐	Results of Tests/Referral Questions	☐
Dependent Care (bringing dependents to appts., scheduling appts., care questions)	☐	Transportation	☐
Include Behavioral Health/Psychiatric Information	☐	Include substance use disorder information	☐

This excludes information related to HIV/AIDS. If you should have any questions regarding the sharing of your health care information, please call your provider's office or speak with one of our Patient Service Associates.

Providers and staff at CHC have my permission to: (Please check all that apply)

( ) Leave message with (name of person): _____

( ) Leave voicemail messages at the following number(s):

Home _____ Cell _____ Work _____

_____

Signature of Patient or Legal Guardian **Printed Name of Patient or Legal Guardian** **Date**

Official Use Only	
Received by/Date:	Processed by/Date: