AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (HIPAA)

Coal Creek Family Medicine wants to assure you that your protected health information is secure with us. Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and/or other relations regarding your medical treatment and patient financial information. Please read below and consider carefully whom you want to have access to your medical and financial information.

I, ________________________________, give Coal Creek Family Medicine my permission to discuss my medical care, or leave a phone message regarding my medical care or information with the following people using the following contact information. I understand that medical care includes my health information, laboratory/radiology results, and/or financial information. I understand this authorization is valid for **1 year** from date of signing unless otherwise revoked.

Preferred e-mail address: ____

Please list which phone number we may leave a detailed message on:

My Cell phone number: __________________________ (if minor (under 18), parent/guardian name) _____________________

My Home phone number: ________________________ (If minor (under 18), parent/guardian name) _____________________

My Work phone number: _________________________(If minor (under 18), parent/guardian name) _____________________

Please list whom we may release your medical information to:

Name: __________________________________ Relationship: _______________________ #:_____________________________

Name: __________________________________ Relationship: _______________________ #:_____________________________

Please list an emergency contact:

Name: __________________________________ Relationship: _______________________ #: ____________________________

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES
I affirm that I have received or read the HIPAA policies of Coal Creek Family Medicine including the Notice of Privacy Practices. I understand that I have the right to request restrictions of the use and disclosure of my health information.
RELEASE OF BILLING INFORMATION
I authorize Coal Creek Family Medicine to release any medical information to such private insurance, the centers for Medicare and CHP+ services and/or any other health insurance plan to the extent such information is needed to determine benefits or benefits payable for related services.
TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
In accordance with the law, we will use and give out your health information to provide you with health care treatments, to get paid for our services, and to help us operate our medical practice.
I authorize Coal Creek Family Medicine to release any medical information to other health care professionals, to people designated by me and who are involved in my care, to auto/life insurance companies in the event of a medical claim, to law enforcement agencies in the event of a criminal investigation, to coroners and funeral directors to allow them to carry out their duties, and for any other purpose required or allowed by law and as required for HIPAA-compliant participation.
RIGHT TO REVOKE THIS AUTHORIZATION
I understand I have the right to revoke this communication authorization at any time, and that the revocation of this authorization must be done in writing and presented to Coal Creek Family Medicine.

Unless otherwise indicated above, my signature below represents my consent to all the above statements and any questions that I had have been answered to my satisfaction.

PRINT PATIENT NAME: ____ DOB: ____________________________

PRINT PARENT/GUARDIAN NAME: ___________________________________

SIGNATURE: ____ TODAY'S DATE: ____________________

Revised 09/15/2020