HURTT family health CLINIC

Permission to Relay Information

Account Number: ____________

DOB: ____________

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information (PHI) be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must provide an alternative address or other method of contacting you.

Hurtt Family Health Clinic will not ask why you are making your request, and will make efforts to accommodate all reasonable requests.

Hurtt Family Health Clinic also utilizes third party entities to disclose certain PHI, including third party medical record coordination, health information exchanges (HIE) with local hospitals and medical providers, and the patient portal.

This request supersedes any prior request for communication of information submitted prior to the date below.

Extended Authorization

Please list any persons you would like to have access to your billing, appointment or health information such as your spouse, caretaker or other family member. This excludes information that is protected under State and Federal law.

Last Name	First Name	Relationship	Phone Number ( )
Last Name	First Name	Relationship	Phone Number ( )
Last Name	First Name	Relationship	Phone Number ( )

If you do not wish to add any extended authorization, please check the box below:

☐ I (the patient) do not authorize to disclose information to anyone (this excludes information that is protected under State and Federal law).

Restrictions on Communication Methods

Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail. Please indicate below any ways in which you do NOT want to receive communications:

☐ No calls to phone number:	☐ No messages or voice mails left on phone number(s):

☐ No mail to the following address:

☐ Health Information Exchange (HIE)	☐ 3rd Party Medical Record Coordination	☐ Patient Portal	☐ Other (specify):

____ ______________

Signature (patient/legal representative) Date

If signed by someone other than patient, indicate relationship: __________________________

Print name: ____

(Legal representative)