LaPine Community HEALTH CENTER

Disclosure of Protected Health Information (PHI)

(HIPAA Form)

Patient Name (please print): _____ **DOB:** _____ **Date:** _____

La Pine Community Health Center may leave a voicemail for the following: (check all that apply)
☐ General information regarding your care ☐ Billing ☐ No messages of any kind ☐ Behavioral health ☐ Substance abuse
Use: ☐ Preferred number only ☐ Any personal number on file
Phone Number: _____

If there is anyone that you would like to give us permission to speak with regarding your healthcare in person or by telephone, please indicate below:
Name: _____ **Relationship**: _____ **Phone**: _____ ☐ Schedule/cancel appointments ☐ Pick up items from clinic, including medications, hard copy RX's, correspondence, etc. ☐ Discuss **ALL** information ☐ Behavior health ☐ Substance abuse
Name: _____ **Relationship**: _____ **Phone**: _____ ☐ Schedule/cancel appointments ☐ Pick up items from clinic, including medications, hard copy RX's, correspondence, etc. ☐ Discuss **ALL** information

Signature (Patient/Legal Guardian): _____ **Date:** _____