



AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name: _____ **DOB:** _____

From time to time it may be necessary for representative of Eastbrook Family Health Center to contact patients for various notification purposes that could include Protected Health Information such as:

- Appointment reminders/confirmation/rescheduling
- Prescription renewal/reminder information
- Lab test results
- Requests to call the doctor for other issues

We would like to know how we can contact you and with whom we can leave a message or share other information about your Protected Health Information.

I authorize Eastbrook Family Health Center physicians and/or staff to contact me and leave messages that could include Protected Health Information pertaining to my care by the methods selected below.

I authorize Eastbrook Family Health Center to leave detailed, personal health information by the following means:

Check and complete all that apply:

	Method	Number w/ Area Code
<input type="checkbox"/>	Home telephone/voice message	
<input type="checkbox"/>	Cell Phone/voice message	
<input type="checkbox"/>	Work telephone/voice message	
<input type="checkbox"/>	Other _____	
<input checked="" type="checkbox"/>	*Email	Via Patient Portal ONLY

* I understand that Physicians' Alliance Ltd. will only use the patient portal to transmit email messages to patients.

AUTHORIZATION TO SHARE PERSONAL HEALTH INFORMATION WITH CERTAIN INDIVIDUALS

In addition, I give permission for the following individuals to receive my Protected Health Information:

Name	Relationship	Number w/ Area Code

With my signature below, I acknowledge and understand that this Authorization will be kept as part of my medical record and that the communication instructions listed above will remain in effect until revoked by me in writing. It is my responsibility to notify Eastbrook Family Health Center in writing should I wish to change any of information noted above and to notify Eastbrook Family Health Center if my contact information changes.

Patient or Legally Authorized Representative's Signature

Date



MRN: _____

**Notice of Privacy Practices
Acknowledgement of Receipt Form**

Patient name: _____ Date of Birth: ____/____/____
(Please Print)

I, _____, acknowledge that I have
(Print Patient Name)
received a copy of the Notice of Privacy Practices for Physicians' Alliance Ltd.

Patient Signature: _____ Date: ____/____/____

or

Patient's personal representative with legal authority to make health care decisions on the patient's behalf.

Personal Representative's Printed Name Relationship to Patient

Personal Representative's Signature: _____ Date: ____/____/____

OFFICE USE ONLY:
If this form is not signed by the patient, or personal representative, complete the following:

The Notice of Privacy Practices was given to the patient or their personal representative on _____ by _____.

The following good faith efforts were made to obtain the signature of the patient, or personal representative: _____

Reason Patient or Personal Representative did not sign this form: _____

Signature: _____ Date: ____/____/____

Print Name: _____ Title: _____