CHESEN LASER EYE CENTER

Patient Authorization for Disclosure of Protected Health Information via Alternative Means **Form 7.34**

Please print all information, then sign and date authorization form at bottom.

Patient Name: ______________________________ **Date of Birth:** ____________

Purpose of Authorization – It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, *"by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care."* The practice requires the following authorization for release of protected health information via alternative means (other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide protected health information (as described below) directly to me at the email address, fax number, phone number, cell phone number or alternative address that I have indicated below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

☐ cell phone: ☐ email address: ☐ US Mail: ☐ fax number: ☐ phone:

____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me *(please provide a written description of the information to be disclosed, such as results of exams, laboratory tests, procedures, and other healthcare services)*:

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Purpose of disclosure – I am authorizing the alternative means of communication for disclosure of my protected health information to ensure the confidentiality of communications from the practice.

Expirations or termination of authorization – This authorization will renew automatically, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.

(Please list desired expiration date):______________________________________

Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in-person or by mailing a written request to the practice, Attn: Privacy Manager.

Non-Conditioning statement: The practice places no condition to sign this authorization on its' delivery of healthcare or treatment.

Redisclosure Statement – I understand that the practice has no control regarding persons who may have access to the mailing address, email address, telephone, cell or fax number I have designated to receive my protected health information. Therefore, I understand that my protected health information disclosed under this authorization will no longer be the responsibility of this practice.

May we leave messages/detailed medical information on voicemail at either of these phone numbers:

Home:________________ Yes_____ No______ Cell:______________ Yes_____ No______

May we contact you at work: Yes_____ No______ Work Number______ __________________

May we leave a message for you at work? Yes_____ No______

May we mail reminder postcards to you for appointments: Yes________ No_______

May we contact you by email? Yes______ No______

Do you authorize us to discuss your personal health information with any particular person(family or otherwise)? This could include gerneral, surgical or billing information? Yes______ No_______

Name:______________________________ relationship_____________ phone:________________

Name:______________________________ relationship_____________ phone_________________

Name:________________________________ relationship___________ phone _________________

Is any one person listed above your **Power of Attorney** for medical purposes? Yes___ No____

Please name which person that is_______________________________________ **Provide Copy**

Alternate number to reach Power of Attorney_____________________

____ __________________

Patient Signature Date