Authorization for Disclosure of Information

Every effort is made to keep your Protected Health Information (PHI) confidential. It is important for us to know your preferences regarding disclosure of PHI. Be aware that there are circumstances in which we are permitted or legally obligated to disclose your PHI to a third party (see Notice of Privacy Practices). In other circumstances, we need your permission for disclosure. Please note that information regarding appointments would not be considered PHI and may be left on an answering machine or voice mail.

May we leave PHI on your voicemail or answering machine? ( ) Yes ( ) No

Please indicate, in order of preference, your desired contact method for results notification or other confidential communication (i.e. preferred phone number, patient portal, family member):

	Name	Relationship	Phone
1.	________________________________	________________	(_____)____________________
2.	________________________________	________________	(_____)____________________
3.	________________________________	________________	(_____)____________________
4.	________________________________	________________	(_____)____________________
5.	________________________________	________________	(_____)____________________
6.	________________________________	________________	(_____)____________________
7.	________________________________	________________	(_____)____________________
8.	________________________________	________________	(_____)____________________

I authorize Fox Ridge Medical Associates to discuss my medical and/or financial information with the above individuals.

I acknowledge that I have read and understand this document, and that in addition I have received a copy of the Fox Ridge Medical Associates Notice of Privacy Practices. I understand that this authorization shall apply unless revoked by me in writing, or until this form is replaced by a newer copy.

Signature of patient (or responsible party) ____

Printed Name____

Date________________________________