

## Consent to Communicate Personal Health Information

In our Notice of Privacy Practices, we informed you that we may disclose your protected health information to those individuals that you identify. By completing this form, you can identify those individuals with whom we can discuss your routine health information such as lab results and future appointments.

1.	directly if we have urgent  Never  On my voicemail at  On my voicemail at	ve you a message about your health ir or sensitive information.)  home # work # n mobile phone #	· · · · ·	
2.	With whom may we discuss your health information? (Please remember this does not apply to calls made from our automated appointment reminder system to your phone number unless you request that we discontinue this service.)  No one The people listed below:			
	Name	Relationship	Phone Number	
	Name	Relationship	Phone Number	
4. For Pediatric Patients: may we communicate with your child's school, daycare or child care provider about your child's health care? Yes No  This consent will remain in effect until revoked by the patient/representative or when the minor patient reaches the age of majority or becomes emancipated. Please notify us of any changes.  This form does not apply to psychotherapy notes as defined by the Privacy Rule 45 CFR 164.501 (for release of pediatric psychosocial health information, use PBH-016; for release of adult psychotherapy notes, use HIP-008)				
Pa	atient's name		Date of Birth	
Si	ignature of Patient, Parent	or Authorized Personal Representative	Date	
Us	e this section to chang	ge preferences:		
	evoke all preferences? lange preferences?	☐ Yes ☐ Yes. Indicate changes below.		

Date

Signature of Patient, Parent or Authorized Personal Representative