

# PHI Communication Form

**IMPORTANT:** This form does not give the authorized person(s) referenced below the permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record.

## Patient Identification

Printed Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Last 4 digits of SSN: \_\_\_\_\_

Telephone: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below.

Authorized person(s) to receive **verbal** information regarding the above patient's care:

Printed Name

Relationship to Patient

Telephone

Printed Name

Relationship to Patient

Telephone

Printed Name

Relationship to Patient

Telephone

Mercy will not release paper or electronic copies of your medical record to anyone including those listed above unless an **Authorization for Use and Disclosure of Protected Health Information or Patient's Request to Access Protected Health Information** form is completed, or Mercy is already permitted by law to do so.

**Mercy may still speak to other persons not listed on this form about your care if otherwise permitted by law.**

I understand I may revoke this authorization at any time and Mercy will cease discussing my Protected Health Information with the above person(s) upon receipt, unless otherwise relied upon or if Mercy is not otherwise required by law to share information with the above person(s).

Patient or Legal Personal Representative: \_\_\_\_\_

Signature

Date: \_\_\_\_\_

Patient or Legal Personal Representative: \_\_\_\_\_

Printed Name

Authority of Personal Representative: \_\_\_\_\_

Patient Name:

MRN#:

Date of Birth:

