RHP Communication of Protected Health Information Authorization

Patient Name: _____ DOB: _____

Please check and fill out all that are acceptable forms of communication to provide quality patient care.

☐ I authorize the staff at Riverview Health Physicians to leave a message regarding my Protected Health Information on my home voicemail or answering machine.

☐ I authorize the staff at Riverview Health Physicians to leave a message regarding my Protected Health Information on my cell phone voicemail.

☐ I authorize the staff at Riverview Health Physicians to leave a message regarding my Protected Health Information on my work voicemail or answering machine.

☐ I authorize the staff at Riverview Health Physicians to mail written communication to my home address.

☐ I authorize the staff of Riverview Health Physicians to speak with the following individuals to discuss medical and/or financial information.

Medical:

Name	Phone	Relationship to Patient

Financial:

Name	Phone	Relationship to Patient

Emergency Contact (Please list one individual not living at the same address):

Name	Phone	Relationship to Patient

All information signed and authorized by me on this form shall remain in effect until my written revocation.

_____ Initial/Date

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HIPAA Privacy Notice Acknowledgement

By initialing below, I acknowledge that I have been advised of the Notice of Privacy Practices of Riverview Health and may obtain a written copy upon request or via the website at riverview.org.

_____ Initial/Date

_____ _____

Patient or legal guardian's signature if patient is a minor Date

*****Staff Use Only*****

Riverview Health Physicians personnel witnessing form completion: _____

Date: _____