COMMUNICATION OF PROTECTED HEALTH INFORMATION

Patient Name:___________________________ **Date of Birth:**____________________________________

I would like__________________________________ to share my protected health information with the
(Behavioral Health Provider at Union Counseling)
individuals (e.g., my spouse, parents, etc.) listed below.

AUTHORIZATION OF COMMUNCATION ONLY – THIS IS NOT A MEDICAL RECORDS RELEASE

Name:____ DOB: _______________________________

Address:____PHONE NUMBER:______________________

____RELATIONSHIP TO PATIENT:_____________

☐SCHEDULING ONLY ☐ PRESCRIPTION REFILLS ONLY ☐BILLING ONLY ☐ATTENDANCE ONLY

☐ALL INFORMATION ☐OTHER____

Name:____ DOB: _______________________________

Address:____PHONE NUMBER:______________________

____RELATIONSHIP TO PATIENT:_____________

☐SCHEDULING ONLY ☐ PRESCRIPTION REFILLS ONLY ☐BILLING ONLY ☐ATTENDANCE ONLY

☐ALL INFORMATION ☐OTHER____

By signing, I hereby authorize the behavioral health clinician listed above to communicate with the individuals listed unless I provide written notice to no longer do so. I understand that completing this form is voluntary and I am not required to list any individuals. I understand that I may revoke my consent in writing at any time.

Signature of Patient/Patient's Representative:____________________________________Date:______________

Print Name of Patient/Patient's Representive:____

Relationship of Representative (parent, guardian, etc.)____

Notary: ____Date:______________________________________

Revocation Section: To Be Completed and Signed by Patient/Patient's Representative

This consent to be revoked on:____

Signature of Patient/Patient's Representative:____

Print Name of Patient/Patient's Representative:____