PLEASE COMPLETE ALL AREAS IN THIS FORM

Batish FAMILY MEDICINE

Permission to Communicate with Caregivers Form

I give consent to Batish Family Medicine to share health information with the people listed below who assist with my care. I understand that this authorization is voluntary. I understand that this lets Batish Family Medicine share certain health information. I understand that sensitive information, like HIV and pregnancy test results, mental health or substance abuse will not be shared unless I fill out the "Authorization to Disclose Health or Billing Information" form. I understand that this authorization is voluntary.

I understand that, the persons or organizations I authorize below are not health care providers and they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Patient Information (please print):

Name: _____ Date of Birth: _____

Protected Health Information to Be Used and/or Disclosed:

☐ Yes ☐ No May we discuss medical information regarding your care, test results, appointments or billing information with someone other than yourself? Please list any individuals you wish to have this permission.

Name	Phone	Relationship

☐ Yes ☐ No May we leave a message regarding your medical care on your voicemail? If yes, please provide the phone number: _____

☐ Yes ☐ No Allow release of information to the American Red Cross for communications with family members of the U.S. military, such as notifying service members of family illness or death, including verifying such illnesses for emergency leave requests. The following information may be provided: Physician Name, Diagnosis, Prognosis, Current Condition, Life Expectancy, and a recommendation for leave.

Expiration: This authorization will remain in place until a notice of change is provided in writing

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____