



**Permission to Share Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Phone Number: \_\_\_\_\_

Please list anyone you give us permission to speak with regarding your protected health information. This information may include: diagnoses, test results, recent visits, medication requests, appointment information, and billing/insurance information.

I authorize the release of my personal health information to the following people:

Name _____	Relationship _____	DOB _____
Phone Number _____		

Name _____	Relationship _____	DOB _____
Phone Number _____		

I authorize Mosaic Health staff to communicate information about me and my care using the following methods (select all that apply):

- Telephone/Voicemail     
  Verbally     
  Email     
  Text Message

**This authorization will remain in effect until revoked by myself verbally or in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.**

**This does not authorize copies of protected health information to be released, mailed, or faxed to the person(s) listed. To obtain paper copies of protected health information, a valid HIPAA release is required.**

**I understand that any disclosure of information carries with it the potential for re- disclosure and the information may not be protected by federal confidentiality rules. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment.**

\_\_\_\_\_ **Check here to indicate that you request NO ACCESS at this time**

\_\_\_\_\_  
Patient Signature (or Parent/Legal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent/Legal Representative

\_\_\_\_\_  
Relationship of Legal Representative

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date