Plumtree Family Health Center

Patient Name: ______________________________________ **Date of Birth:** ________________

Protected Health Information (PHI) Release

Please read carefully and print legibly.

****Complete all THREE sections and sign the bottom.****

Please select how you authorize Plumtree Family Health Center to share important PHI with you.

Home Telephone (_____) _____ - ___________

☐ I give PFHC permission to leave a message on my home phone with detailed PHI

Work Telephone (_____) _____ - ___________

☐ I give PFHC permission to leave a message on my work phone with detailed PHI

Cell Phone (_____) _____ - ___________

☐ I give PFHC permission to leave a message on my cell phone with detailed PHI

Written\Electronic Communication

☐ I give PFHC permission to mail detailed PHI to my home address.

☐ I give PFHC permission to send detailed PHI through my e-mail address; provided below.

__________________________________@______________________.com

I authorize Plumtree Family Health Center to release my Protected Health Information to the following individuals:

Name: __________________________________ Relationship: __________________

Name: __________________________________ Relationship: __________________

Name: __________________________________ Relationship: __________________

OR ☐ I do not want any information released regarding my healthcare at PFHC.

Emergency Contacts:

1) Name: __________________________________ Relationship: ______________________

   Home Phone: ____________________________ Cell Phone: ______________________

2) Name: __________________________________ Relationship: ______________________

   Home Phone: ____________________________ Cell Phone: ______________________

Patient Signature: ______________________________ **Date:** __________________

This form should be updated on an annual basis. Please contact our office with changes prior to annual review.