mountainvieweyes.com

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# PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION VIA ALTERNATIVE MEANS

Patient Name _____ Date of Birth: _____

**Purpose of Authorization:** It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, *"by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care."* The practice requires the following authorization for release of protected health information (PHI) via alternative means (other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide PHI to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

☐ cell phone: ☐ email address: ☐ US Mail: ☐ fax number: ☐ phone:

_____

**Description of information to be disclosed:** I authorize the practice to disclose the following PHI about me. *(Provide a written description of the information to be disclosed)*

_____

_____

**Purpose of disclosure:** I am authorizing the alternative means of communication for disclosure of my PHI to ensure the confidentiality of communications from the practice.

**Expiration or termination of authorization:** This authorization will renew automatically, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.

(Please list desired expiration date): _____

**Right to revoke or terminate:** As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in person or by mailing a written request to the practice, Attn: Privacy Manager.

**Non-Conditioning Statement:** The practice places no condition to sign this authorization on its delivery of healthcare or treatment.

**Redisclosure Statement:** I understand that the practice has no control regarding persons who may have access to the mailing or email address, telephone, cell or fax number I have designated to receive my PHI. Therefore, I understand that my PHI disclosed under this authorization will no longer be the responsibility of this practice.

**Secure Communication:** Note that some email and fax transmission methods are not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice. Do not designate email or fax as your preferred method of communication if this is of concern to you.

_____ _____

Patient Signature Date

Copies of signed authorizations are available