PARIS LAKES HEALTH GROUP

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PATIENT AUTHORIZATION TO CDISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY/PROVIDER OF CARE

I, _____, understand Alois Pauls, MD and Paris Lakes Health Group, and the office staff is authorized by me to disclose my Protected Health Information the manner(s) that I have checked below and to the people that I have listed below.

I wish to be contacted in the following manner: (check all that apply)

☐ Home Phone: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with callback number only

☐ Work Phone: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with callback number only

☐ Cell Phone: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with callback number only

☐ Written Communication: _____
- ☐ OK to mail to my home
- ☐ OK to mail to my work/office
- ☐ OK to fax to this number: _____

Name(s) of person(s) authorized by this form to disclose my protected health information:

Name(s) and Relationship(s):

_____	☐ Medial Information	☐ Appt/Testing
_____	☐ Medial Information	☐ Appt/Testing
_____	☐ Medial Information	☐ Appt/Testing
_____	☐ Medial Information	☐ Appt/Testing

I understand that I have the right to revoke anyone listed on the authorization and must fill out the form before the revocation can be completed.

All revocations must be sent to Alois Pauls, MD and Paris Lakes Health Group, to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

I fully understand and accept the terms of this authorization.

_____ _____
Patient Signature Date