Authorization for Communication of Protected Health Information to Family and Friends

Patient Name ____________________ Date of Birth ____________

Home Phone Number ____________________ Cell Phone Number ____________________

Address ____________________ City ____________ State ______ Zip ______

I, ______________________________, authorize Mountainview to discuss/share my protected health information with the following individual(s):

Name	Relationship	Phone Number

Type of information to be shared or disclosed:

- ☐ Appointment Information
- ☐ Medical Information
- ☐ Prescription Information
- ☐ Mental Health Information
- ☐ Lab/Imaging Results
- ☐ Any Information

☐ **I do not authorize** Mountainview to share my protected health information with any individuals.

I authorize Mountainview to leave detailed messages about my medical and health information on the following:

- ☐ Cell Phone Voicemail
- ☐ Home Phone Voicemail

Signature: ______________________________ Date: ______________

(This authorization shall remain in effect until revoked by the patient or for 1 year. You may request a new form at any time. Submitting a new form will replace the existing form.)

741 NE 6th Street, Grants Pass, OR 97526
Phone (541) 471-2701 • **Fax** (541) 471-1166