Authorization to Release Protected Health Information to Delegate

Patient Name (print):____ **DOB:** _____________

By signing this form, I authorize CHI St. Luke's Medical Group to disclose protected health information such as office consultations, labs, radiology and other test results to the person or people listed below. I understand that it is my responsibility to update this release form if necessary and/or remove delegates.

CHI St. Luke's Medical Group May Release my protected health information to the following people:

Name:_________________________Relationship to Patient: ______________Phone#___________________

Name:_________________________Relationship to Patient: ______________Phone#___________________

Name:_________________________Relationship to Patient: ______________Phone#___________________

Preferred Contact Method

CHI St. Luke's Medical Group will often contact patients for appointment reminders and testing results. Please indicate the method in which our office may contact you and or leave messages on authorized phone numbers.

_____Initial Primary Contact Number ___________________________________ cell/home/work/other

_____Initial Secondary Contact Number _________________________________ cell/home/work/other

_____Initial I do not wish to be contacted in any other manner than a direct conversation, no messages may be left.

Patient /Guardian Signature_____________________________________

Authorization and Assignment Acknowledgement Form

My signature certifies I have read and understand the content of the Auth. & Assignment Acknowledgement document.

Patient / Guardian Signature_____________________________________

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____ **Date:** ________________________

Patient / Guardian Signature

____ ______________________________

Relationship (if not the patient) **SLMG Witness**