St. Joseph Medical Center
St. Mary's Medical Center

Medical Information Authorization

Name: (Please Print)_____ Date of Birth:_____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicates that you have been given the opportunity to review and/or request a copy of the Prime Healthcare Medical Groups Notice of Privacy Practice on the date indicated. If you have any questions regarding the information in the Prime Healthcare Medical Group's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Medical Group's Patient Privacy Officer as indicated on your Notice.

**The above authorization is required by Federal Law under HIPAA regulations.*

Medical Information Authorization

o * I DO NOT authorize my medical care Provider to leave a voicemail message on my phone which I provided to you in my demographic information.

o * **I DO** authorize my medical care Provider to leave a voicemail message on my phone which I provided to you in my demographic information.

o * I DO NOT authorize the physician or anyone associated with his/her group to discuss my medical condition, treatment or test results with anyone other than myself.

o * **I DO** authorize the physician or anyone associated with his/her medical Group to discuss my medical condition, treatment and test results with the following people (family/friends, not to include physicians):

Name:_____ Phone:_____ Relationship:_____

[ ] Any Info regarding my health/appointments/insurance [ ] Only info regarding: _____

Name:_____ Phone:_____ Relationship:_____

[ ] Any Info regarding my health/appointments/insurance [ ] Only info regarding: _____

Name:_____ Phone:_____ Relationship:_____

[ ] Any Info regarding my health/appointments/insurance [ ] Only info regarding: _____

Name:_____ Phone:_____ Relationship:_____

[ ] Any Info regarding my health/appointments/insurance [ ] Only info regarding: _____

Signature of patient or legal representative:_____ Date:_____/_____/_____

Printed name of patient/legal representative:_____ Relationship:_____