Park Allergy Center
430 W Centre Ave, Portage, MI 49024
Phone: 269-321-6673 Fax: 269-324-5594

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 test and to provide information that describes or recommends alternatives regarding your care." The practice requires the following authorization for release of protected health information via alternative means(other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide protected health information (as described below) directly to me at the fax number, phone number, cell phone number or alternative address that I have indicated 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.

☐ US Mail (Please Print)

Name:_____

Street Address:_____

City, State, Zip:_____

☐ Cell Phone:_____ Fax Number:_____ Phone:_____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me. Please check the information to be disclosed.

☐ Complete Record ☐ Operative Reports ☐ Physician Notes ☐ Lab Reports ☐ Pathology Reports

☐ Correspondence ☐ Radiology Reports ☐ Other:_____

Purpose of disclosure - I am authorizing the alternative means of communication for disclosure of my protected health information to ensure the confidentiality of communications from the practice.

Expiration of 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. 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. Park Allergy Center, 430 W Centre Ave, Portage, MI 49024 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 address, telephone, cell or fax number I have designated to receive my protected health information. Therefore, I understand that my protected health information disclosed under this authorization will no longer be the responsibility of this practice.

Patient Signature:_____ Date:_____