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HIPAA Compliant Medical Information Sharing Authorization Form

Protected Health Information Sharing Designation

I, _____, grant permission for the person whose name is printed below to receive information regarding my medical care from the Karle Medical Group without additional authorization, and outside of my presence. By providing a name below and signing this form, I understand that the individual named below will have access to my medical records without additional consent unless and until consent is explicitly revoked in writing.
If no name is indicated above, then no layperson will have access to any information contained in my health record from Karle Medical Group.

Spouse: _____

Relative: _____

Caregiver:_____

Other Relationship:_____

Protected Health Information Messages

I **authorize** _____ /**prohibit** _____ the communication of detailed health information by the staff of Karle Medical Group in the form of voice-mail or answering-machine messages at my contact telephone number.

_____

_____ _____
Signed Date

_____
Print Name of Signatory

_____ _____
Witnessed Date

_____
Print Name of Witness

Please return this document to the Karle Medical Group reception desk upon completion.