"Healing with Heart" Elica Health Centers

PROTECTED HEALTH INFORMATION AUTHORIZATION FORM - HIPAA

Elica Health Centers is committed to protecting your health information. This **HIPAA disclosure/non-disclosure form** allows you to add, update, or change how your protected health information is shared. This form helps us understand any new instructions you have about what details, if any, you would like us to share with the people in your life. Elica providers will only communicate with patients regarding their treatment or care in person, telephonically, or via the patient portal.

Patient Information

Last Name:	First Name:	Middle Initial:	Date of Birth:

Message Preferences: Tell us the type of messages you prefer and what we can share. (Messaging and data rates may apply.)

	Phone	Text	Email/Portal
All of the below	☐	☐	☐
Health Notifications (such as lab or test results)	☐	☐	☐
Appointment Reminders	☐	☐	☐
Announcements (such as new programs or community information)	☐	☐	☐
Billing Notifications	☐	☐	☐

Who: Tell us who you would like us to share, or release, information with. Each box is for a different person.

Person #1

First and Last Name:

Relationship:
☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Sister ☐ Brother
☐ Aunt ☐ Uncle ☐ Wife ☐ Husband ☐ Partner ☐ Guardian

☐ Other _____

☐ We can tell this person any and all of your medical information.

OR

☐ We can give this person today's chart notes at the time of the visit.

☐ We can give this person all of your test results.

Person #2

First and Last Name:

Relationship:
☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Sister ☐ Brother
☐ Aunt ☐ Uncle ☐ Wife ☐ Husband ☐ Partner ☐ Guardian

☐ Other _____

☐ We can tell this person any and all of your medical information.

OR

☐ We can give this person today's chart notes at the time of the visit.

☐ We can give this person all of your test results.

Person #3

First and Last Name:

Relationship:
☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Sister ☐ Brother
☐ Aunt ☐ Uncle ☐ Wife ☐ Husband ☐ Partner ☐ Guardian

☐ Other _____

☐ We can tell this person any and all of your medical information.

OR

☐ We can give this person today's chart notes at the time of the visit.

☐ We can give this person all of your test results.

Person #4

First and Last Name:

Relationship:
☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Sister ☐ Brother
☐ Aunt ☐ Uncle ☐ Wife ☐ Husband ☐ Partner ☐ Guardian

☐ Other _____

☐ We can tell this person any and all of your medical information.

OR

☐ We can give this person today's chart notes at the time of the visit.

☐ We can give this person all of your test results.

☐ **I do not want ANYTHING told or shared with ANYONE.**

By signing this **HIPAA disclosure/non-disclosure form**, I authorize Elica Health Centers to update and share my health information according to the changes I have indicated above. This authorization supersedes any previous authorizations I have provided to share my protected health information, and applies only to the information and individuals listed on this form.

This authorization to share your private health information will expire **1 year from the date of signing** this **HIPAA disclosure/non-disclosure form** or upon (describe terminating event) _____.

_____ _____
Print First and Last Name of Patient | Relationship to Patient (e.g., self, parent, guardian)

_____ _____
Patient / Guardian Signature | Date

Office Use Only

Effective Date:		Updated By:	