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:**

Communication Preferences: Type of communication you prefer and what we can share (data rates may apply)

	Mail	Phone	Text	Email	Portal
To Do			☐	☐	
News and Announcements	☐	☐	☐	☐	☐
Questionnaires				☐	
Account Management			☐	☐	
Telehealth				☐	
Appointments	☐	☐	☐	☐	☐
Billing	☐		☐	☐	
Health	☐	☐	☐	☐	☐
Messages	☐	☐	☐	☐	☐
Other Communication	☐	☐	☐	☐	☐

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 will expire **1 year from the date of signing** 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:** ______________________________