Fiat Family Medicine

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Patient Communication Form for Privacy Practices

Patient Name: _____ Date of Birth _____

This Authorization grants permission to the Designated Party(s) named below to: make or confirm appointments; have access to imaging, laboratory, or other test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up sample medications; be made aware of my diagnosis, prognosis, and treatment plans; and/or have access to my financial health information at this practice in order to assist with the management of my care.

I hereby authorize Fiat Family Medicine to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand once this information is disclosed to the Designated Party(s) named below, the released information may no longer be protected by federal privacy regulations.

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

☐ I choose no to release my information to anyone.

Signature: _____ Date: _____

This consent will be in effect beginning _____ and ending _____, or until revoked by me in writing.