mosaic health
Better happens together.

Patient Name:_____Date of Birth:_____/_____/_____

Address:_____

Phone Number: _____

Please list anyone you give us permission to speak with regarding your protected health information. This information may include: diagnoses, test results, recent visits, medication requests, appointment information, and billing/insurance information.

I authorize the release of my personal health information to the following people:

Name_____Relationship_____DOB_____

Phone Number_____

Name_____Relationship_____DOB _____

Phone Number_____

I authorize Mosaic Health staff to communicate information about me and my care using the following methods (select all that apply):

☐Telephone/Voicemail ☐Verbally ☐Email ☐Text Message

This authorization will remain in effect for *one year* or until revoked by me in writing. Understand that the revocation will not apply to information that has already been released based on this authorization.

This does not authorize copies of protected health information to be released, mailed, or faxed to the person(s) listed. To obtain paper copies of protected health information, a valid HIPAA release is required.

I understand that any disclosure of information carries with it the potential for re- disclosure and the information may not be protected by federal confidentiality rules. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment.

_____Check here to indicate that you request NO ACCESS at this time

_____ _____
Patient Signature (or Parent/Legal Representative) Date

_____ _____
Print Name of Parent/Legal Representative Relationship of Legal Representative

_____ _____
Witness Date