CATHOLIC HEALTH INITIATIVES

Franciscan Medical Group

A Part of Franciscan Health System

Patient Name: _____
Account #: _____
Date of Service: _____

Obtaining Verbal/Written Permission to Use or Disclose Protected Health Information

From time to time the Franciscan Medical Group may wish to use or disclose your protected health information to individuals involved in your care for notification purposes. As stipulated by the Title 45, Section 164.10, we are permitted to make such uses or disclosures ***after we have obtained your verbal or written permission.***

Franciscan Medical Group is authorized to: *(Please check all that apply.)*

- ☐ Notify or speak with my spouse regarding treatment or proposed treatment.
  (please specify name): _____
- ☐ Notify or speak to my caregiver regarding treatment or proposed treatment.
  (please specify name): _____
- ☐ Notify or speak to my family members, i.e., children, sister, brother, mother, father of treatment or proposed treatment.
  (please specify name(s): _____
- ☐ Notify or speak to my friend regarding treatment or proposed treatment
  (please specify name): _____
- ☐ Notify my transportation service regarding my delivery or pick-up prior to or upon completion of my treatment.
  (please specify name): _____
- ☐ Other (please specify): _____

How may we contact you with reference to your appointment, proposed treatment, follow up appointments, billing questions/problems, surgery scheduling, Doppler appointments, lab testing, radiology, and other situations regarding your protected health information?
See below:

If I am not available, Franciscan Medical Group may: *(please check all that apply)*

- ☐ Leave a message with my spouse or those members listed above.
- ☐ Leave a message on my answering machine, voice mail or cell phone.
- ☐ Call my place of employment and leave a message for me to return the call.
- ☐ Leave a message with my dialysis facility when I cannot be reached through normal channels.
- ☐ Leave a message with my referring doctor's office to have me return the call.
- ☐ Leave a message with my interpreter *(for foreign speaking patients*)
- ☐ Other: _____

_____ _____
Patient/Guarantor Signature Date

_____ _____
Print Name Date of Birth