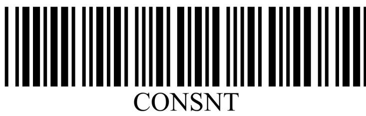

CoxHealth
All Entities and Locations
www.coxhealth.com

Name: ____________________
Age: _____ DOB: ______________
Acct or SSN: __________________
(or Patient Sticker Here)

PERMISSION TO SHARE

Permission to Verbally Share Information with Those Involved in Your Care

(Signed original will be scanned into Cerner and a copy will be provided to the patient.)

Many patients want their healthcare provider to verbally share medical and/or billing information with specific family members, friends, or others participating in their care. The purpose of this annual authorization is to communicate with your healthcare provider regarding who may have access to this information.

Patient Identification:

Legal Name: ____ Date of Birth:____/____/______

Full Address: ____

I authorize the release of financial and protected health information (PHI) from the following:

__ The entire CoxHealth systemand its Affiliated Covered Entities.

__ Do not disclose information from the following entity(s): ____________________________

- In the case of an emergency situation CoxHealth may determine that a limited disclosure may be in my best interests and I realize CoxHealth may share limited PHI or other information with those who may be involved in my care.
- I realize this form does NOT authorize the person(s) below to make healthcare decisions for me or to view or receive copies of my medical records.

			Type of Information			
Name:	Phone Number:	Relationship to Patient:	All	Scheduling / Appointment	Medical	Insurance / Billing

This covers the following time frames. If NOT marked, all past, present and future encounters are the default.

__ All past, present, and future encounters/visits -OR- Other: ____________________________

By signing this authorization form, I understand that:

- PHI may include records relating to psychiatric or psychological care; communicable diseases; HIV/AIDS diagnosis or treatment; alcohol or drug abuse treatment; sexually transmitted diseases; and other sensitive information.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Time Limit and Right to Revoke:
Except to the extent that action has already been taken in reliance on this authorization, I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to my physician's clinic if I am a clinic patient or registration/nursing staff if I am a hospital patient. Unless otherwise revoked, this authorization will expire one (1) year from the date signed.

Signature of Patient / Legal Representative:

______________________________________ Date: __________ Time: __________

Relationship to Patient: ____