AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name:_____ **DOB:**_____

From time to time it may be necessary for representative of General Internal Medicine to contact patients for various notification purposes that could include Protected Health Information such as:

- Appointment reminders/confirmation/rescheduling
- Prescription renewal/reminder information
- Lab test results
- Requests to call the doctor for other issues

We would like to know how we can contact you and with whom we can leave a message or share other information about your Protected Health Information.

I authorize General Internal Medicine physicians and/or staff to contact me and leave messages that could include Protected Health Information pertaining to my care by the methods selected below.

I authorize General Internal Medicine to leave detailed, personal health information by the following means:

Check and complete all that apply:

	Method	Number w/ Area Code
☐	Home telephone/voice message	
☐	Cell Phone/voice message	
☐	Work telephone/voice message	
☐	Other_____	
X	***Email**	**Via Patient Portal ONLY**

*** I understand that Physicians' Alliance Ltd. will only use the patient portal to transmit email messages to patients.**

AUTHORIZATION TO SHARE PERSONAL HEALTH INFORMATION WITH CERTAIN INDIVIDUALS

In addition, I give permission for the following individuals to receive my Protected Health Information:

Name	Relationship	Number w/ Area Code

With my signature below, I acknowledge and understand that this Authorization will be kept as part of my medical record and that the communication instructions listed above will remain in effect until revoked by me in writing. It is my responsibility to notify General Internal Medicine in writing should I wish to change any of information noted above and to notify General Internal Medicine if my contact information changes.

Patient or Legally Authorized Representative's Signature Date