RHP COMMUNICATION OF PRIVATE HEALTH INFORMATION AUTHORIZATION

Patient Name:____________________ **DOB:**________________

Please √ and fill out all that are acceptable forms of communication to provide quality patient care.

- ☐ I authorize the staff of Riverview Health Physicians to leave a message regarding my Private Health Information on my home voicemail or answering machine.
- ☐ I authorize the staff of Riverview Health Physicians to leave a message regarding my Private Health Information on my cell phone voicemail.
- ☐ I authorize the staff of Riverview Health Physicians to leave a message regarding my Private Health Information on my work voicemail or answering machine.
- ☐ I authorize the staff of Riverview Health Physicians to mail written communication to my home address.
- ☐ I authorize the staff of Riverview Health Physicians to speak with the following individuals to discuss Medical and/or Financial information.

Medical:

Name	Phone Number	Relationship to Patient

Financial:

Name	Phone Number	Relationship to Patient

Emergency Contact: (Please list one individual not living at the same address)

Name	Phone Number	Relationship to Patient

All information signed and authorized by me on this form shall remain in effect until my written revocation.

______________ Initial/Date

HIPAA PRIVACY NOTICE ACKNOWLEDGMENT

By initialing below, I acknowledge that I have been advised of the Notice of Privacy Practices of Riverview Health and may obtain a written copy upon request or via the website at www.riverview.org.

______________ Initial/Date

____ ____________________

Patient or Legal Guardian's signature if patient is a minor Date

STAFF USE ONLY

Riverview Health Physicians personnel witnessing form completion.____________________________

Date: ____________________