YOUR PRIVACY OPTIONS
Receipt of Privacy Practices & HIPAA Authorization

This form is to help us know what details, if any, you would like us to share with the people in your life. You can also tell us how you want information shared. Telling PRHS how you want to share information is called HIPAA Authorization and it's from the Health Insurance Portability and Accountability Act (HIPAA). This form also helps us to know that we have asked to give you our privacy practices.

Personal Details: Tell us about yourself or the person this form is for.

Last Name:_____ First Name:_____ Middle Initial:_____
Nickname:_____ Date of birth:_____

Name of Parent, Legal Guardian, or Conservator: (Only if any of these apply to you.)
_____

Messages: This is where you tell us if we can leave you voice messages and what we can share.

You allow PRHS To:
____ Leave voice messages at the phone number you've given us.
_____ Leave voice messages about your appointments at the phone numbers you've given us.
____ Leave voices messages about labs or tests results at the phone numbers you've given us.

If you do not want ANYTHING told or shared with ANYONE check and sign here:___
Signature:_____

Who to share with and what we can share: This is where you tell PRHS who you would like us to share, or release information with. Each box is for different person.

Who can we share your information with? (Optional)
Person #1:_____DOB:_____Relationship:_____

With this person, you allow PRHS to:
____We can tell this person any and all of my medical information.
____We can give this person today's chart notes at the time of the visit.
____We can give this person all of your test results.
____This person is allowed to pick up your prescription medication.

This patient is under 18years old and this person is allowed to give permission and make decisions for: __Medical/Dental visits ___Immunizations(This person must bring ID in at the time of visit)

Who can we share your information with? (Optional)

Person #2:_____DOB:_____Relationship:_____

With this person, you allow PRHS to:

____We can tell this person any and all of my medical information.

____We can give this person today's chart notes at the time of the visit.

____We can give this person all of your test results.

____This person is allowed to pick up your prescription medication.

This patient is under 18years old and this person is allowed to give permission and make decisions for: __Medical/Dental visits ___Immunizations(This person must bring ID in at the time of visit)

Who can we share your information with? (Optional)

Person #3:_____DOB:_____Relationship:_____

With this person, you allow PRHS to:

____We can tell this person any and all of my medical information.

____We can give this person today's chart notes at the time of the visit.

____We can give this person all of your test results.

____This person is allowed to pick up your prescription medication.

This patient is under 18years old and this person is allowed to give permission and make decisions for: __Medical/Dental visits ___Immunizations(This person must bring ID in at the time of visit)

Sign & Initial Here:

Print name here_____

Sign:_____Date:_____

I was asked if I wanted a copy of PRHS's Notice of Privacy Practices._____(Initial)

Parent/Guardian/Conservator:

Sign:_____Date:_____

This approval ends one year from the date signed or updated in writing

Office use Only:

Received by:_____Date:_____

Scanned by:_____Date:_____