PATIENT AUTHORIZATION AND COMMUNICATION CONSENT FORM

Patient Communication Authorization: *Patients in our practice may be contacted via phone, email or text messaging to be reminded of an appointment, or to provide general health benefits/information or to complete patient surveys.*

Patient FIRST Name (PRINT)	Patient LAST Name (PRINT):	
Date of Birth:	Today's Date:	Chart Number (Staff Entry Only)
Cell Phone Number: May we text you? ☐ Yes ☐ No	Home Phone Number:	
Email:		

It is important to note that text communication is not secure (encrypted). Text messages can be intercepted and for this reason, we will not communicate personal health information through this method.

Acknowledgement of Notice of Privacy Practices: Windsong's Notice of Privacy Practices is available on our website or can be provided to you in our office. You are encouraged to read it. By signing below, you acknowledge that you are aware of how Windsong may use & disclose your health information and how you can exercise your privacy rights. Any questions should be directed to the privacy officer listed in the notice of privacy practices.

Signature of Patient or Representative (with relationship):____

Authorization to Disclose Information: I authorize the release of health information including but not limited to all information listed below (unless individually selected not to share) to the individual(s) listed below (i.e. spouse, children). *This section is only completed if you wish to provide information to someone other than an applicable provider.*

Individual(s)(with relationship): ____

If you wish ***only specific information*** released to the individual(s) listed above. Please provide specific **exceptions** below by checking each relevant box:

Yes	No	
☐	☐	Appointment Details Only
☐	☐	Radiology or Imaging Reports
☐	☐	Appointment Information and Preparation Details
☐	☐	Medication Records
☐	☐	Office Notes
☐	☐	Physician Orders
☐	☐	Complete Medical Record
☐	☐	Laboratory (including drug screening) & Pathology Reports
☐	☐	Billing – to Discuss Insurance or Patient Bills
☐	☐	Genetic Testing & Family History
☐	☐	Other _______________________________

Signature of Patient or Legal Representative: ____

At any time, you have the ability to revoke what you have indicated above.