Authorization to Share Protected Health Information

Attach patient label here

Person-to-Person Communication

To help with my care or billing, my care team may discuss detailed information with the people listed below. I understand this form is optional and is used to allow verbal communication between my caregivers and those listed below. It may also let these persons pick up medicines or papers on my behalf (if so detailed at the bottom of the form).

_____ _____ _____
First and last name (please print) *Relationship to patient* *Best contact number*

Please share: ☐ Scheduling information ☐ Medical information ☐ Billing information ☐ Pick up items

_____ _____ _____
First and last name (please print) *Relationship to patient* *Best contact number*

Please share: ☐ Scheduling information ☐ Medical information ☐ Billing information ☐ Pick up items

_____ _____ _____
First and last name (please print) *Relationship to patient* *Best contact number*

Please share: ☐ Scheduling information ☐ Medical information ☐ Billing information ☐ Pick up items

I understand the following:

- This consent applies to Fairview Health Services, HealthEast facilities and services, Range Regional Health Services, Grand Itasca Clinic and Hospital, M Health Fairview, and University of Minnesota Physicians and to the information in the common electronic health record used by those organizations and other clinics. The clinics are listed at https://www.fairview.org/Medical-Records/Electronic-Health-Record.
- This authorization does not include access to or copies of my medical record. I must fill out another form for this.
- If the person or persons listed will be involved in my health care decisions, I must appoint them as a health care agent through a health care directive or other legal appointment.
- This form does not have an end date. If I want to change the information on this form, I will fill out a new form. If I want to add or remove people for person-to-person communication, I will fill out another form.
- Once my information is shared with the person or persons named above, it may no longer be protected by privacy laws. We cannot prevent these persons from sharing my information with a third party.
- If I do not sign this form, I will still be treated.
- There are no restrictions on the information checked above that may be discussed. If I wish to exclude specific information (such as treatment for mental health, chemical dependency or infectious disease), I will detail those instructions here:

_____ _____ _____
Signature of patient or authorized person *Print name* *Date/Time*

_____
Authorized person's authority to sign (proof required)

Reason patient is unable to sign: ☐ Minor ☐ Other: _____

*Interpreter Name:*_____*Language/Organization:*_____