



## Medical Information (HIPAA) Release Form

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

By listing the persons below, I am authorizing any employee Brookside Family Medicine to release information contained in my patient records, which may include alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any social services records, if any mental health records, including communications made by me to a social worker or mental health professional, if any and all information defined by statute and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV) test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC), if any, to the individuals listed below, only under the conditions listed below:

**Do not release any information to anyone.**

**I authorize information to be released to:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Emergency Contact :** (This person **WILL NOT** be authorized access to any medical information unless indicated above)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### ***Communication from doctor's office:***

1. I would like to receive patient notifications\* via (circle one): **Text** or **Automated Phone Call**

\*May include appointment confirmation, prescription refills, notification of lab results

2. What information may we include on your voicemail? (NOT automated calls)

**Detailed Message** or **Call Back Only**

3. We have a patient portal through the Healow App! You can use it to message your provider, view lab results, and join TeleVisits. Do you want to sign up? An email address is needed.

Email: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Office Use:** EMessenger \_\_\_\_\_ Contacts Entered \_\_\_\_\_ Sticky Note \_\_\_\_\_