La Pine Community Health Center
Disclosure of Protected Health Information (PHI)
(HIPAA Form)

Patient Name: _____ DOB: _____

La Pine Community Health Center values the privacy of its patients and is committed to operating its practice in a manner that promotes patient confidentiality while providing high quality patient care.

At times, La Pine Community Health Center has a need to reach you for reasons related to care (for example, to discuss lab results or medication).

☐ I give my permission to La Pine Community Health Center to give protected health information to the following people in person, on the phone, and/or by leaving a voice mail message: (for example: lab or x-ray results, test results, medication information)

Name:_____ Relationship:_____ Phone #_____

Name:_____ Relationship:_____ Phone #_____

Name:_____ Relationship:_____ Phone #_____

Name:_____ Relationship:_____ Phone #_____

Names appearing above- do not need to be added below

☐ I give my permission to leave messages **(without giving protected health information)** with the person answering the phone or on voicemail at the following numbers:

Location or name: _____ Phone #_____

Location or name: _____ Phone #_____

Location or name: _____ Phone #_____

Signature _____
(Patient/Parent/Guardian Signature)

Print Name_____

Date_____