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Allergy & Asthma Center of NC

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DESIGNATED PARTY RELEASE

We request that you complete this form when consenting for us to leave detailed verbal information (results of labs, x-rays, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, or e-mail, or with another party that you choose to designate.

This form does not allow copies of your medical records to be released. To release copies of your medical records, you must complete a Request & Authorization for Use/Disclosure of Protected Health Information form.

Note: The "Health Care Providers Guide-Communicating with a Patient's Family, Friends, or Others Involved in the Patient's Care," the U.S. Dept. of Health and Human Services, Office for Civil Rights, provides the following information: Even though HIPAA requires health care providers to protect patient privacy, providers are permitted, in most circumstances, to communicate with the patient's family, friends, or others involved in their care or payment for care, without obtaining written authorization from the patient. You can find more information about HIPAA at this website: http://www.hhs.gov/ocr/hipaa.

Patient name (*PRINT*) _____ Date of Birth _____

Today's Date _____

At my request, I authorize ☐ all Cone Health Medical Group Practices or ☐ Cone Health Allergy and Asthma Center of NC to verbally disclose my protected health information, as needed, to (enter name of person(s)/entity who may be allowed to receive protected health information):

Name: _____ Name: _____

Address: _____ Address: _____

City/State/ZIP: _____ City/State/ZIP: _____

Phone Number: _____ Phone Number: _____

Relationship to Patient: _____ Relationship to Patient: _____

At my request, I authorize Cone Health Allergy and Asthma Center to communicate my protected health information to me via the following methods:

☐ Leave detailed message on my home answering machine (phone #: _____)

☐ Leave detailed message on my voice mail at work (phone #: _____, ext: _____)

☐ Leave detailed message on my cell phone voice mail (phone #: _____, ext: _____)

Patient Signature: _____ **Date:** _____

*******IMPORTANT NOTICE BELOW*******

PROCEDURE TO CANCEL THIS AUTHORIZATION:
I understand that I may revoke this authorization at any time in writing. However, if I revoke this authorization, I also understand that the cancellation will *not* affect any action taken in reliance on this authorization before receipt of the written notice of cancellation.