Physicians' Alliance, Ltd.

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name:____ **DOB:**____________

From time to time it may be necessary for representative of Cornerstone Family Health Associates to contact patients for various notification purposes that could include Protected Health Information such as:

- Appointment reminders/confirmation/rescheduling
- Prescription renewal/reminder information
- Lab test results
- Requests to call the doctor for other issues

We would like to know how we can contact you and with whom we can leave a message or share other information about your Protected Health Information.

I authorize Cornerstone Family Health Associates physicians and/or staff to contact me and leave messages that could include Protected Health Information pertaining to my care by the methods selected below.

I authorize Cornerstone Family Health Associates to leave detailed, personal health information by the following means:
Check and complete all that apply:

	Method	**Number w/ Area Code**
☐	Home telephone/voice message	
☐	Cell Phone/voice message	
☐	Work telephone/voice message	
☐	Other_______________________	
X	***Email**	**Via Follow My Health Patient Portal ONLY**

*** I understand that Physicians' Alliance Ltd. will only use the patient portal to transmit email messages to patients.**

AUTHORIZATION TO SHARE PERSONAL HEALTH INFORMATION WITH CERTAIN INDIVIDUALS

In addition, I give permission for the following individuals to receive my Protected Health Information:

Name	**Relationship**	**Number w/ Area Code**

With my signature below, I acknowledge and understand that this Authorization will be kept as part of my medical record and that the communication instructions listed above will remain in effect until revoked by me in writing. It is my responsibility to notify Cornerstone Family Health Associates in writing should I wish to change any of information noted above and to notify Cornerstone Family Health Associates if my contact information changes.

____
Patient or Legally Authorized Representative's Signature   Date

OVER ➔

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MRN: ___________

PHYSICIANS' ALLIANCE LTD.
Notice Version: 10/14/13

Notice of Privacy Practices Acknowledgement of Receipt Form

Patient name: ____________________________________**Date of Birth**:___/___/___
(Please Print)

I, ____, acknowledge that I have received a copy of the Notice of Privacy Practices for Physicians' Alliance Ltd.

Patient Signature:_______________________________________ **Date**:___/___/___

or

Patient's personal representative with legal authority to make health care decisions on the patient's behalf.

______________________________________ __________________________

Personal Representative's Printed Name **Relationship to Patient**

Personal Representative's Signature:_______________________ **Date**:___/___/___

OFFICE USE ONLY:
If this form is not signed by the patient, or personal representative, complete the following:

The Notice of Privacy Practices was given to the patient or their personal representative on_________________________________ by _____________________________.

The following good faith efforts were made to obtain the signature of the patient, or personal representative: ____
____.

Reason Patient or Personal Representative did not sign this form: _________________
____.

Signature:____ **Date**:___/___/___

Print Name:_________________________________ **Title**:________________________