



Consent for Sharing of Protected Health Data and Information

\* This form does not authorize the release of medical records\*

1. Please list the names and relationship of family members or other persons, if any, whom we may inform verbally about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

1. \_\_\_\_\_ 3. \_\_\_\_\_
2. \_\_\_\_\_ 4. \_\_\_\_\_

2. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home address.

\_\_\_\_\_
\_\_\_\_\_

3. Please print the telephone numbers where you want to receive calls about your appointments, lab and test results, or other health care information.

- HOME \_\_\_\_\_
WORK \_\_\_\_\_
CELL PHONE\* \_\_\_\_\_
OTHER PHONE \_\_\_\_\_

\* I am fully aware that a cell phone is not a secure and private line

4. Can confidential messages (i.e. appointment reminders, test results, etc.) be on your telephone answering machine or voicemail?

YES \_\_\_\_\_ NO \_\_\_\_\_

PATIENT NAME \_\_\_\_\_
CHART NUMBER \_\_\_\_\_ AGE IF MINOR \_\_\_\_\_

X \_\_\_\_\_ Date of signing \_\_\_\_\_
Signature of Patient

X \_\_\_\_\_ Time of signing \_\_\_\_\_
Signature of Patient's Representative

\_\_\_\_\_ X \_\_\_\_\_
Representative's Relationship to Patient Witness Signature (Office Representative)

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