RICHTER
Family Medicine
& Wellness

5500 W. Friendly Ave Suite 201
Greensboro, NC 27410
(P) 336-897-0004 (F) 336-897-3003
Richterfamilymedicinewellness@gmail.com

Chart _____

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, voicemail at work, cell phone, or email, or with another party 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 Provides 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 of Civil Rights, provides the following Information: Even though HIPAA requires health care providers to protect patient privacy, providers permitted, in most circumstances, to communicate with patient's family, friends, or others involved in their care, without obtaining written authorization from the patient. You can find more information about HIPAA at this website: http://www.hhs.gov/ovr/hipaa)

Patient name: (PRINT) _____ Date of Birth: _____
Today's Date: _____

At my request, I authorize: [ ] Richter Family Medicine &Wellness, or [ ] Only this specific practice: (specify)_____, to verbally disclose my protected health information, as needed, to (enter name of person(s)/entity who may be allowed to receive your protected health information):

Name: _____ Name: _____
Address: _____ Address: _____
City/State/Zip: _____ City/State/Zip: _____
Relationship to Patient: _____ Relationship to Patient: _____

At my request, I authorize: **[ ] Richter Family Medicine & Wellness, or [ ] Only this specific practice: (specify) _____, to communicate my protected health information via the following methods:**

[ ] Leave detailed message on my home answering machine (phone #: _____)
[ ] Leave detailed message on my voice mail at work (phone #: _____)
[ ] Leave detailed message on cell phone voice mail (phone #: _____)

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.