THIS FORM MUST BE COMPLETED BY THE GUARANTOR :______________________________

PHI Communication Form

Patient Identification

Printed Name: ________________________________

Address: ________________________________

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Date of Birth: ____________________

Last 4 digits of SSN: ____________________

Telephone: ____________________

I, ________________________________, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below.

Authorized person(s) to receive **verbal** information regarding the above patient's care:

Printed Name	Relationship to Patient	Telephone

Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record.

Mercy will not release paper or electronic copies of your medical record to any one including those listed above unless an ***Authorization for Use and Disclosure of Protected Health Information*** form is completed or Mercy is already permitted by law to do so.

Mercy may still speak to other persons not listed on this form about your care if otherwise permitted by law.

I understand I may revoke this authorization at any time and Mercy will cease discussing my Protected Health Information with the above person(s) upon receipt, unless otherwise relied upon or if Mercy is not otherwise required by law to share information with the above person(s).

Patient or Legal Personal Representative: ________________________ Date: __________
Signature

Patient or Legal Personal Representative: ________________________
Printed Name

Authority of Personal Representative: ________________________

Patient Name:
MRN#:
Date of Birth: