K. Anthony Shanbour, M.D.
Obstetrics & Gynecology

PROTECTED HEALTH INFORMATION AUTHORIZED PERSON(S)

Please print below information

I,____, hereby authorize release of my Protected Health Information for **verbal discussion only** of my care and treatment to the person(s) specified below (45CFR, 164.502[F] & 164.502[G]): Authorized family member or person to receive information for the above named patient's care:

___________________________ ________________________ _______________
Name of Central Contact (other than patient) Relationship to Patient Phone

Others authorized to receive my verbal information (please list names and relationship):

___________________________ ________________________ _______________
Name of Central Contact (other than patient) Relationship to Patient Phone

___________________________ ________________________ _______________
Name of Central Contact (other than patient) Relationship to Patient Phone

NOTE: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper copies or electronic access of your medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations.

- **Leave message on answering machine or voice mail?**
(Example : We may leave message reminders , scheduling changes or notices that lab results are in on your answering machine. Would this process be acceptable, yes or no?) ☐ Yes ☐ No

- **Leave message for patient to return call?**
(Example: We may leave a message regarding appointment reminders , scheduling changes or notices that lab results are in with an individual who answers the phone. Would this process be acceptable , yes or no?) ☐ Yes ☐ No

NOTE: By signing and dating this Protected Health Information Authorized Person(s) form, I revoke all previously signed Protected Health Information Authorized Person(s) forms.

Patient Signature ____________________________ Date____________________________

Personal Representative ________________________ Relationship to Patient ___________________

(PRINTED Name)

NOTE: Except to the extent that action has already been taken in reliance on this Protected Health Information Authorized Person(s), at any time I can revoke this Protected Health Information Authorized Person(s) by submitting a new Protected Health Information Authorized Person(s) form or by written notice to Mercy where my medical records are kept.

Patient Name: ____________________________ Date of Birth: __________________