Unity health network

Pulmonary, Critical Care
& Sleep Medicine

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please list below the names and contact information of individuals you authorize to receive your Personal Health Information (PHI)

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Home Phone:_____ Home Phone:_____

Cell Phone:_____ Cell Phone:_____

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Home Phone:_____ Home Phone:_____

Cell Phone:_____ Cell Phone:_____

For security purposes, please fill in one of the personal identifiers on the right so that we may verify whom we are speaking with before sharing your Personal Health Information (PHI)

Mother's Maiden Name:_____

Your city of birth:_____

Your favorite color:_____

Create your own identifier:_____

On occasion we may need to call you and leave information regarding results of any treatments or tests that you have had.

May we leave this information on your voicemail? Yes No

May we leave appointment reminders on your voicemail? Yes No

If yes, please list your preferred contact number. Preferred phone #:_____

Please list the name(s) below of the individual(s) that you would like us to contact in case of emergency:

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Home Phone:_____ Home Phone:_____

Cell Phone:_____ Cell Phone:_____

I,_____, do hereby acknowledge receipt of the Notice of Privacy Practices, Policies and Procedures.

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____