MARGARET MARY HEALTH

P.O. Box 226 • 321 Mitchell Avenue
Batesville, IN 47006
Phone: 812.934.6624

Patient Label

AUTHORIZATION TO DISCUSS AND/OR VIEW PROTECTED HEALTH INFORMATION WITH OTHERS

Patient Name: _____ Date of Birth: _____

Parent Name(s) - If patient is a minor: _____

Margaret Mary Health understands there may be times when other individuals may request information regarding your health care, such as a spouse or sibling. In this instance, the protected health information for said patient cannot be disclosed without authorization. In order to allow other individuals to call, request or view information, we need this form completed. Please review the below authorization and list those individuals who may contact us for your protected health information.

Authorization
I give my permission for Margaret Mary Health to discuss my protected health information, including treatment, payment and health care operations, using the minimum necessary standards, to the below individuals.

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

With this authorization, I am acknowledging I understand Margaret Mary Health will discuss my protected health information with the individual(s) listed above. This authorization is valid indefinitely unless revoked in writing.

Patient/Representative Signature: _____ Date: _____

ROI