Aegis Medical Center

Internal Medicine

PROTECTED HEALTH INFORMATION DESIGNATION FORM

I_____, give my permission for Aegis Medical Center to release any of the following information about my medical condition, financial account, and prescriptions as specified below:

Patient Contact Preference:

Phone Number_____ May leave detailed voicemail _____ YES _____NO

Email Address_____

Name and Phone Number of Person	Information to be Released
Name: _____ Phone Number: _____	____Financial ____Medical Information ____Prescriptions
Name and Phone Number of Person	Information to be Released
Name: _____ Phone Number: _____	____Financial ____Medical Information ____Prescriptions
Name and Phone Number of Person	Information to be Released
Name: _____ Phone Number: _____	____Financial ____Medical Information ____Prescriptions

In case of a medical emergency or in cases otherwise permitted or required by law, written authorization will not be necessary. Please see Notice of Privacy Practices for additional details. You may make changes to your protected health information in writing at any time.

Patient Name:_____ Date of Birth_____

Signature: _____ Date: _____

Relationship, if other than the Patient: _____

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