Main Line HealthCare
Physician Network

Authorization to Disclose Protected Health Information- Form Z PHI

Communicating with a Patient's Family and Personal Representatives

The Health Insurance Portability and Accountability Act or HIPAA is a law that protects your health information. To make sure we disclose information about your treatment only to those individuals designated by you, please complete this form.

Patient Name_____**DOB**_____**Date**_____

1. In accordance with HIPAA Privacy Rules, I understand that my Main Line HealthCare (MLHC) provider and care team is able to communicate with me using a variety of methods. These methods include the use of direct mailings and telephone communications. I understand that MLHC will only use the most current demographic and contact information that I provide and is documented within my Main Line HealthCare medical record. I consent to receive calls from MLHC that include my Protected Health Information (PHI) and other health related information. I authorize my MLHC provider and care team to leave voicemails on the lines associated with the telephone numbers in my medical record, and I understand that these messages may contain information about my care. I understand that if the telephone number is a wireless (cell) number, I may be charged for such calls by my wireless provider and that such calls may be generated by an automated dialing system.

   Patient initials_____

2. I hereby authorize the disclosure of my Protected Health Information when requested by me, or notification in the event of a medical emergency, to the individuals named below. I understand this authorization is voluntary.

Name	Relationship	Contact Phone Number

   I understand that this authorization does NOT include information related to treatment for any of the following medical diagnoses or conditions unless specifically indicated. To authorize the additional release of this specific information, please place your initials next to each item(s) below:

   _____HIV/AIDS ____Psychiatric care/treatment ____Drug or alcohol treatment

   _____STD ____Pregnancy

3. I understand that I can revoke this authorization at any time by notifying my treating physician or a member of the office staff in writing, except to the extent that the physician practice has taken any action in reliance on this authorization, and that in any event, this authorization will expire one year from the date it was initially signed.

_____ _____ _____

Print Name Signature Date