ADELANTE HEALTHCARE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) BY PHONE OR IN-PERSON

AB37.MED.AGR

I give Adelante Healthcare permission to **verbally discuss and/or leave messages** about my Protected Health Information (PHI) in the manner indicated on this authorization form. I am aware of who may answer the telephone at the numbers I provided. I am comfortable with Adelante Healthcare leaving detailed messages at these telephone numbers and/or on the patient portal. In addition to my medical/dental care information, Adelante Healthcare can disclose/discuss the following super-confidential information (please check all that apply):

☐ Mental Health ☐ Alcohol abuse or test results ☐ Drug/substance abuse or test results ☐ Psychotherapy records	☐ Sexually transmitted infections/diseases ☐ Sexual Assault Nurse Examiner Program (SANE) documents ☐ Developmental disabilities ☐ HIV test results, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related disease

This authorization does not allow Adelante Healthcare to release paper copies of my PHI to anyone.

The person(s) I authorize to receive my PHI is not required to follow the federal privacy standards. I understand that he or she may share my PHI without my knowledge or authorization. Adelante Healthcare is not responsible for any claims and/or damages arising from discussing my PHI in response to this authorization.

I acknowledge that I am not required to sign this authorization form. Adelante Healthcare may not condition treatment or payment for health care based on whether I sign this form.

This authorization is effective until my legal guardian, my legal representative, my representative, or I request to cancel it. I have the right to cancel this authorization at any time by sending a written request to the Adelante Health Center where I receive care or to Adelante Healthcare Center Support Office, Attn: Medical Records Department, 9520 W. Palm Lane, Suite 200, Phoenix, AZ 85037. Cancellation does not apply to PHI already released in response to this authorization.

Patient's First Name/Middle Initial/Last Name	Date of Birth
_____	_____

I give Adelante Healthcare permission to leave messages and communicate verbally on the telephone or face-to-face detailed protected health information (PHI) known about me now and in the future. Adelante Healthcare may leave general telephone appointment reminders and messages requesting that I call back even if I do not sign this form.

☐ Yes

☐ No

PHI that may be discussed and/or messages left include:

- *Appointment reminders (provider name and department)*
- *Test and procedure results*
- *Billing or payment information*
- *Other health information*

(If "Yes", complete this form. If "No", do not answer the following questions)

Home Number:	(_____) _____ Area Code Phone Number	☐ Yes	☐ No
Cell Phone Number:	(_____) _____ Area Code Phone Number	☐ Yes	☐ No
Work Phone Number:	(_____) _____ Area Code Phone Number	☐ Yes	☐ No

Adelante is authorized to discuss my care with:

Name	Relationship	Gender
Name	Relationship	Gender
Name	Relationship	Gender
Name	Relationship	Gender

I understand what information about me may be communicated with my contacts. This accurately reflects my wishes. I authorize Adelante Healthcare to use the information I have provided on both pages of this form.

Patient or Legal Guardian Signature	Date
Adelante Witness (only required if patient or guardian unable to sign)	Date

Staff: Send copy of form to Patient Portal