Excelsior Primary Care Clinics
Excelsior Specialty Clinics

Permission to Disclose Information to Those Involved in My Care

This form does not authorize releasing copies of my medical records.
I hereby allow the primary care clinics of Excelsior Springs Hospital to disclose the following information:

Check all that apply.

☐ Appointment times and dates
☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan.
☐ Tests that have been performed
☐ Test results
☐ Billing/payment information

Other health information (describe)_____

To the following people who are involved with my healthcare and/or payment information.
Check all that apply and list names and phone numbers.

☐ Spouse _____ Phone _____

☐ Friend _____ Phone _____

☐ Child(ren) _____ Phone _____

☐ Other _____ Phone _____

Can confidential messages (i.e. appointment information, prescription information, test results) be left on your answering machine or voicemail?

Check all that apply.

☐ No, DO NOT leave messages.

☐ Yes, at home Home Phone _____

☐ Yes, at cell Cell Phone _____

☐ Yes, at work Work Phone _____

I understand that in certain situations the primary care clinics of Excelsior Springs Hospital could speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.
I understand that I have the right to review (stop) my permission at any time.

Patient name (please print): _____ Date of Birth: _____

Patient / Guardian Signature: _____ Date: _____

<u>If patient is a minor, please complete the following information:</u>

Mother's name /contact information: _____

Father's name / contact information: _____

This form must be updated annually.