HOUSTON PHYSICIANS' HOSPITAL

DIRECTION FOR THE LIMITATIONS, MODIFICATIONS, OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

PART 1

You may leave messages on my answering machine or voicemail regarding appointment reminders, test results, etc and indicate the office name/physician name.

❑ I give permission to leave a message ❑ I do NOT give permission to leave a message.

When I am in the facility under your treatment and care, you have my permission to disclose pertinent information to family members, friends or designated caregivers who may be present with me. (I understand that if I am not present in the facility, you will not disclose my personal health information unless I personally agree to the disclosure). Family members, friends, or designated caregiver must provide passcode as applicable to obtain updates.

❑ Yes See Part 2 ❑ No See Part 3

PART 2

If you wish to give permission for such communication**, please complete one of these two options**. If you do not choose an option, we will not disclose any information:

❑ I give permission to discuss my treatment of condition with persons who identify themselves as my family members, friends, or designated caregivers when I am not present to consent

❑ I give permission to discuss my treatment or condition ONLY with the following person(s) when I am not present to consent

Name: _____ Name: _____

Relationship:_____ Relationship: _____

Surgery, Observation or Inpatients

PART 3

I understand that I will be contacted after discharge by a nurse to assess my postoperative progress.
Please choose preferred method of contact:

❑ Please only contact me (the patient).

The best number to reach me is _____ the best time is: ❑ AM ❑ PM

❑ I do NOT give permission to leave a message ❑ Do not contact me (the patient) postoperatively

OR I designate _____ to receive the call at phone number _____

The best time to call is: ❑ AM ❑ PM

Patient/Legal Representative Signature _____

Relationship to Patient _____ **Date** _____/_____/_____ **Time** _____ **AM/PM**

*I understand this form remains valid for **the respective calendar year**. I can revoke this form at any time by providing notice in writing, dated with a date that is later than the date on this form, and signed by me or my legal representative.*

«Last_Name», «First_Name»
Age: «Age» «Birth_Date» Sex: «Sex»
DOS: «Admit_Date»
Att: Dr.«Attending_Physician_First_Name» «Attending_Physician_Last_Name»
VisitID: «Visit_ID»
MRN: «Medical_Record_Number»