ALLOWANCE FOR CONFIDENTIAL COMMUNICATIONS TO A THIRD PARTY

Name of Patient: ______________________________ Date of Birth: __________
(Please print)

I grant permission for UAH Faculty and Staff Clinic to give information with regard to my medical care to the following person(s) or entity(ies). I understand that I may withdraw, in writing, one or all of these requests at any time.

Name of person given permission to receive medical information.	Relationship to patient (friend, spouse, other family member or physician)
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

I grant permission for UAH Faculty and Staff Clinic to leave messages as designated below:

	APPOINTMENT/REMINDER/CHANGES	TEST RESULTS
HOME	YES NO	YES NO
WORK	YES NO	YES NO
CELLULAR PHONE	YES NO	YES NO

______________________________ Date__________
Patient Signature

Privacy Practices Acknowledgement

I have received and had the opportunity to review the Notice of Privacy Practices

Signature ______________________________

For Practice Use Only:

Practice: ☐ Accepts ☐ Denies

Privacy Officer Signature: ______________________________

Date: ______________________________

LCO/srw June 2007