ARIZONA ARRHYTHMIA CONSULTANTS

Authorization and Restriction of PHI

(PHI – Protected Health Information)

Patient Name: _____ **Date of Birth:** _____

Cell: _____ **none**

Home: _____ **none/same as cell**

Work: _____ **none/retired**

Appointment information (appointment reminders, reschedule requests, etc.):

On which phone may we leave messages regarding your appointment information?

(circle all that apply) Home Cell Work None

Account/Billing information (test results, prescriptions, treatment info., etc.):

On which phone may we leave messages regarding your appointment information?

(circle all that apply) Home Cell Work None

Medical Information (test results, prescriptions, treatment info., etc.):

On which phone may we leave messages regarding medical information?

(circle all that apply) Home Cell Work None

Is there anyone else we may or may NOT discuss your PHI with?

NOTE: We will not discuss your PHI with anyone NOT listed on this form.

Name(s) _____

Relationship _____

yes/no appt info (i.e. reschedule requests/appt reminders)
yes/no account/billing
yes/no medical (lab results, prescriptions, treatment info)

WE MAY NOT DISCLOSE YOUR PHI TO:

Name(s) _____

Relationship _____

yes/no appt info (i.e. reschedule requests/appt reminders)
yes/no account/billing
yes/no medical (lab results, prescriptions, treatment info)

Patient Signature: _____ **Date:** _____