Blanchard Valley HEALTH SYSTEM

Authorized HIPAA Representative
Limited Information

I understand that Blanchard Valley Health System will not disclose personal health information to other parties, except those directly involved in my care, without my written authorization. Unless authorized, BVHS will not release confidential health information by home telephone, answering machine, work telephone, voice mail, or cell phone. It is recognized that in some circumstances this may not be practical to support effective communications. If you would like BVHS to use one of these methods or release information to someone other than yourself, please complete the following.

I authorize Blanchard Valley Health System to leave limited health information pertaining to my care (e.g. review of pre-procedure instructions, post-procedure follow up, call to receive results of testing, etc.) by the following designated methods. I assume responsibility to notify BVHS if this information changes.

Please note: this authorization does not provide your 'Authorized Representative" with any authority, either implied or direct, over any treatment of direct care decisions. Also, this authorization does not permit the release of medical records nor the disclosure of any information pertaining to Behavioral Health.

			Phone Number (if yes):
Home Telephone	_____***no***	_____***yes***	_____
Answering Machine	_____***no***	_____***yes***	
Work Telephone	_____***no***	_____***yes***	_____
Voice Mail	_____***no***	_____***yes***	
Cell Phone and/or Voice Mail	_____***no***	_____***yes***	_____
Texting	_____***no***	_____***yes***	_____
Fax Number	_____***no***	_____***yes***	_____

Please list the names of any people you authorize to directly receive messages or information regarding your personal medical information.

Spouse/Partner: _____ Phone Number: _____

Parent: _____ Phone Number: _____

Other(s): _____ Phone Number: _____
(& relationship)

Please list any additional instructions you may have for use or release of information regarding your healthcare.

_____

_____

_____

I understand I have the right to revoke or discontinue this authorization at any time. I understand that if I do not wish the person named to remain an Authorized Representative, I must remove this authorization in writing.

_____ _____
Signature of Patient or Legal Representative/relationship Date

_____ _____
Hospital Representative Date/Time