BMG | BAPTIST MEDICAL GROUP

AUTHORIZATION TO LEAVE MESSAGES

Patient Last Name _____ First Name _____ Middle Initial _____ Suffix _____ (Jr/Sr/II etc.)

Address _____ City _____ State _____ Zip _____

Date of Birth _____/_____/_____

Which of the following communications means are appropriate/acceptable for BMG to communicate with you: (please check all that apply)

☐ Home phone # ☐ Okay to leave a message? ☐ Yes ☐ No

☐ Cell phone # ☐ Okay to leave a message? ☐ Yes ☐ No

☐ Work phone # ☐ Okay to leave a message? ☐ Yes ☐ No

With whom may we share information about your health? Please list below.

Note: In order for BMG to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) identifiers listed below:

1. Last 4 digits patient's social security number **2. Patient's date of birth** **3. Patient's zip code**

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Name	Relationship to You	Telephone Number	May Discuss Diagnosis/Treatment	May Discuss Billing Info
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Do you have a legal document that states who will make decisions if you are unable? ☐ Yes ☐ No

If yes, Name _____ Relationship to Patient _____

Check one: ☐ Healthcare Proxy/Agent ☐ General Power of Attorney ☐ Healthcare Power of Attorney

If you would like information about appointing a healthcare proxy/agent, please let us know.

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature: _____ Date: _____

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