Designated Party Release

Patient Name: _____ Date of Birth: _____

Eagle Physicians and Associates is authorized to release protected health information about the above named patient in the following manner and/or to selected person(s).

Check each method of communication approved to send information:

Check type of information that can be given via the assigned method on the left in the same section:

☐ **Email Communication - Provide email address**

_____

- ☐ Medical
- ☐ Financial
- ☐ Appointment reminders
- ☐ **All of the above**

☐ **Text Communication - Provide phone number**

_____

- ☐ Appointment reminders

☐ **Voice Mail - Provide Phone Number(s)**

_____

- ☐ Medical
- ☐ Financial
- ☐ Appointment reminders
- ☐ **All of the above**

☐ **Other person(s) - Provide Name and Phone Number**

Name	Number	Relation
Name	Number	Relation
Name	Number	Relation

- ☐ Medical
- ☐ Financial
- ☐ **All of the above**

☐ **FOR EMAIL AND/OR TEXT COMMUNICATION, I UNDERSTAND THAT IF INFORMATION IS NOT SENT IN AN ENCRYPTED MANNER THERE IS A RISK IT COULD BE ACCESSED INAPPROPRIATELY. I STILL ELECT TO RECEIVE EMAIL AND/OR TEXT COMMUNICATIONS AS SELECTED ABOVE.**

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient Date