Eagle Designated Party Release

Patient Name:_____Date of Birth:_____AR #: _____

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

Email Communication: Eagle uses email communication for appointment reminders, telehealth visits, form completion, electronic statements, billing notifications, patient portal account, and may request follow up regarding previous visits with your provider.

Email Address:_____

Text Communication: Eagle uses text communication for appointment reminders, telehealth visits, form completion, appointment changes, and may request follow up regarding previous visits with your provider.

Text Phone Number:_____

Voicemail Communication: Eagle uses voicemail communication for appointment reminders, appointment changes, lab results, referral details, prescription refills, or other medical recommendations.

Voicemail Phone Number:_____

Other person(s) we may contact– Please list anyone who you allow us to speak with regarding your medical information and/or financial information.

If you do not list anyone in this space we will not be able to speak with anyone other than the patient.

Name	Phone Number	Relation
Name	Phone Number	Relation
Name	Phone Number	Relation

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 my treatment will not be conditional on signing.

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

_____ _____

Signature of Patient/Legal Guardian Date

EAGLE PHYSICIANS