WELLSTAR Health System

Patient Communication Designation

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Information *(please print clearly):*

Last Name	*First Name*	*Middle Initial*	*Date of Birth (Month / Day / Year)*
Street Address	*Apt. # / P.O. Box # (Please include complete mailing address)*		*Medical Record # / Social Security # (optional)*
City	*State*	*Zip Code*	*Primary Contact Number*

If we cannot reach you at the telephone number listed above, WellStar may contact you (including leaving messages) regarding appointments or **normal** lab results at the following number(s):

Business Number	*Cell Phone Number*	*Other Phone Number*

I authorize WellStar Health System to disclose Protected Health Information to the following persons:

☐ Spouse: _____
Name *Phone Number*

☐ Child(ren): _____
Name *Phone Number*

_____
Name *Phone Number*

☐ Other: _____
Name *Phone Number*

Information to be disclosed:

☐ All Medical Information ☐ Laboratory Results ☐ All Billing / Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WellStar location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WellStar cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WellStar is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature / Date:

(date authorization signed by patient or Legal Guardian / Personal Representative) _____
Month / Day / Year

Print Patient Name or Name of Legal Guardian / Personal Representative	***Signature of Patient or Legal Guardian / Personal Representative***

Indicate relationship to patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*