Norfolk Medical Group at Fountain Point

GEBHARDT PIERCE BOESCH

Patient Name **Patient Date of Birth**

_____ _____

This form is intended for you, the patient, to give us, Norfolk Medical Group, permission to discuss your treatment with whom you provide in the table below.

I hereby authorize Norfolk Medical Group Physicians/Nurses to discuss my Protected Health Information (PHI) as described in this authorization. l understand that my PHI may include, but is not limited to, the following: progress notes, labs, x-rays, and any information related to the purpose of this authorization.

I further understand that my PHI may include information related to any of the following: mental health, HIV/AIDS, and chemical dependency, including alcohol and drug treatment.

I further understand that this authorization applies to ALL PHI, except for the following limitations (if none, please leave blank):

_____

_____

Please tell us who you are authorizing Norfolk Medical Group/your Physician/Nurse to discuss your PHI by completing the table below.

Name of person to discuss your PHI with your Physician	Person's Relationship to you	Date of Birth	Telephone Number	Can we leave test results or messages with this person? Y/N

Identification will be verified.

You have the right to revoke your authorization at any time, in writing, except to the extent that Norfolk Medical Group has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

Patient Signature/Guardian/POA _____ Date: _____

The method by which I would like to be contacted:

Cell Phone _____ Home Phone _____ Leave message: Yes No

If this authorization is signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative Name: _____

Relationship with the Patient

_____ Legal Guardian. Please attach legal documentation showing that you are the Legal Guardian.

_____ Power of Attorney. Please attach legal documentation that you hold a Power of Attorney. If you hold a Health Care Power of Attorney, it must be accompanied by a Doctor's certification of incapacity.

********* Please return to Norfolk Medical Group Health Information to put on file. *********

Updated: 4/7/23