OneCore Health

Release of Protected Health Information to Family Members and Person Involved in Patient's Care or Payment

With your permission, OneCore Health may release your protected health information to a family member or another person involved in your care or payment for your health care. For example, OneCore Health may tell a family member when your procedure is scheduled; discuss your care or payment involved. By completing the top portion of this form, you are authorizing OneCore Health to release this information to these individuals.

However, ***you are not authorizing OneCore Health to provide extensive information about your medical history or copies of information from your medical record***. If you wish to have this information disclosed, *you must complete a separate HIPAA authorization form*.

Please be aware that OneCore Health may use its professional judgment in determining the amount of information it may disclose to any person besides yourself, and in refusing to disclose your health information.

Please identify the person or persons who are involved in your care or the payment of your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

Name	Relationship

Authorization to Leave Voice Messages and Send Email Messages

OneCore Health is required to have your permission to leave voice messages regarding your Protected Health Information. Please check the appropriate boxes:

☐ **YES**, OneCore Health **may** leave a message on my answering machine/voice mail regarding my Protected Health Information.

☐ **NO**, OneCore Health **may not** leave a message on my answering machine/voice mail regarding my Protected Health Information.

☐ **YES**, OneCore Health **may** send me emails regarding my Protected Health Information including outstanding balances.

Please provide a current/valid email address: _____

☐ **NO**, OneCore Health **may not** send me an email regarding my Protected Health Information.

I understand that if I change my mind about any of the information in this form, I must contact OneCore Health to revoke this form in its entirety or to complete a new form.

_____ _____

Patient and/or Legal Guardian Signature Today's Date

_____ _____

Print Patient Name Patient Date of Birth