BOYLAN HEALTHCARE
Trusted Care For Your Well-Being

PHONE: 919-781-9650
FAX: 919-781-3572

PROTECTED HEALTH INFORMATION DESIGNATION FORM

Patient Name: _____ Chart # _____ Birth Date: _____

You may give Boylan Healthcare written authorization to disclose your protected health information (PHI) to anyone you designate and for any purpose.

Please complete the questions below. Only provide information which you consider acceptable as a means of contacting you and your designated contacts. In the case of a serious medical emergency or in cases otherwise permitted or required by law, this written authorization will not be necessary. Please see Notice of Privacy Practices for details.

You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing PHI about you.

My Home Number: _____ OK to leave message on voice mail? Yes / No

My Work Number: _____ OK to leave message on voice mail? Yes / No

My Cell Number: _____ OK to leave message on voice mail? Yes / No

My Email: _____ OK to send email? Yes / No

My mailing address for test results, appointments, billing issues:

_____

_____

At my request, I authorize Boylan Healthcare to disclose my PHI to:
You may leave this blank if you do not wish any disclosures be made.

Name: _____ Phone Numbers: _____

Address: _____

Relationship to Patient: _____

Specific Information You'd like them to know OR not know: _____

_____

_____

_____

(Continue on Separate Page if Needed)

Signature _____ Date _____