PALMETTO FAMILY MEDICINE AND SENIOR CARE
HIPAA FORM

Designated Party Release

You may give PFMSC written authorization to disclose your protected health information to anyone that you designate. If you wish to authorize a person to receive your protected health information, please indicate below. You may also indicate how you would prefer for our office to communicate with you concerning your lab and test results, prescription refills, and appointment reminders.

- **I authorize PFMSC to disclose my Protected Health Information (PHI) to the following individuals:**

  Name: _____

  Phone:_____

  Name: _____

  Phone:_____

  Name: _____

  Phone:_____

- **I authorize PFMSC to communicate my Protected Health Information to me via the following methods:**
  - ☐ **MedBook (electronic health record)- received via email/text**
  - ☐ **Home Phone: _____**
  - ☐ **Cell phone voicemail: _____**

Authorized signature: _____ Date: _____

REVISED 1/2024