Derry Medical Center
Personal Information Authorization Release

Phone Calls including Patient Test Results/ Medical Information, Patient Portal Authorization Form, Health Reminders

We recognize it is important to receive medical information and test results in a timely manner. With this form you can authorize permission for us to leave messages on a machine and/or designate a second party to receive this information via telephone to help deliver medical information to you as soon as it is available.

Patient Name: ____**DOB:**_____________ EMAIL____________________________
(Please Print CLEARLY)

What is your PREFERRED Phone #?___________________________________**Cell#:** ____

My voicemail message is: Personalized ☐ **Generic** ☐ ******We cannot leave messages on work place voicemails.**
Authorization:

I authorize DMC/LFP to leave a clinical message for: (check all that apply)

☐ Imaging/Lab/Test Results ☐ Insurance Approvals/Denials ☐ Medication/Refill Requests ☐ ALL listed

Please List Any Restrictions:____

Patient Clinical Messages: I authorize DMC/LFP to leave **the MESSAGE listed above** on my: (check all that apply)

☐ Home Answering Machine ☐ Cell Phone ☐ Direct Mail ☐ ALL listed

I authorize DMC/LFPC to speak to ______________________________________ regarding ☐ any test results and/or ☐ anything related to my healthcare. (Relationship)______________. EMERGENCY CONTACT: ____________________________PHONE#___________

RELATIONSHIP: _______________________________

Patient Portal Users:

I authorize _____________________________to have access to my patient portal account that houses my medical information via the following email address: _____________________________________login. I understand that by sharing the same email address for multiple family members allows the person receiving the email to set any family member up with a username and password on my behalf and may have full access to that information.

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PATIENT PRIVACY PRACTICES & EMAIL AUTHORIZATION

I acknowledge that:
I was offered the "Notice of Patient Privacy Practices" from Derry Medical Center

I authorized automated appointment/health reminders through telephone/text messaging/email (check here to OPT OUT ☐ **)**

I authorize email communication for our Patient Portal and practice information and alerts (check here to OPT OUT ☐ **)**

Note: Email through the patient health portal is more secure than traditional email. We recommend joining our patient portal as a communication tool to our practice. Patient portal requires secure log in information and your medical information is protected electronically. We do not utilize regular email communication and recommend that you use a personal email address and not a business address. PROXY authorization must be completed on a separate form.

Patient Signature or Parent/Legal Guardian **(If under 18 yrs-Relationship)** **(Date)**

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Release information (for Medicare/Medicaid patients only)

I request that the payment of authorized Medicare/insurance benefits be made to me or on my behalf to Derry Medical Center for any services furnished me by that provider. Ii authorize any holder of medical information about me to release to the **Centers for Medicare and Medicaid Services (CMS)**, and its agents any information needed to determine benefits or the benefits payable for related services.

Signature:____**Date:** ___________________

10/2015 DD

***** Authorization is considered permanent unless we are notified in writing of any changes.*****