Main Line HealthCare
Physician Network

Authorization to Disclose Protected Health Information

Contacting Patients and Communicating with Family/Personal Representatives

Patient Name_____**DOB**_____**Date**_____

1. I authorize Main Line HealthCare and its affiliates and business associates to contact me about my accounts, my care, appointment reminders, informational communications about health related programs and services, and debt collection purposes. Ways that I authorize Main Line HealthCare to contact me are the following: direct mail, electronic mail, telephone, cell phone (voice or text), including voicemail messages. To contact me Main Line HealthCare may also use an automatic dialing system or pre-recorded forms of voice/messaging systems. Main Line HealthCare may use any of the telephone/cell phone numbers, email addresses and mailing addresses contained in my medical record. I understand that these contacts, communications, messages and texts may include my Protected Health Information and other health related information about me. I understand that there may be some level of risk that information in an unencrypted electronic transmission could be read by a third party and I accept this risk. I understand that if the telephone number is a cell phone number, I may be charged for such calls or texts by my wireless service provider. I permit a copy of this authorization to be used in place of the original.

   Patient initials_____

2. I hereby authorize the disclosure of my Protected Health Information when requested by me, or notification in the event of a medical emergency, to the individuals named below. I understand this authorization is voluntary.

Name	Relationship	Contact Phone Number

   I understand that this authorization does NOT include information related to treatment for any of the following medical diagnoses or conditions unless specifically indicated. To authorize the additional release of this specific information, please place your initials next to each item(s) below:

   _____HIV/AIDS ____Psychiatric care/treatment ____Drug or alcohol treatment

   _____STD ____Pregnancy

3. I understand that I can revoke this authorization at any time by notifying my treating healthcare provider or a member of the office staff in writing, except to the extent that the Main Line HealthCare practice has taken any action in reliance on this authorization, and that in any event, this authorization will expire one year from the date it was initially signed.

_____ _____ _____

Print Patient Name | Signature of Patient or Authorized Representative | Date