Somerville Family Practice

1020 Broadway
Somerville MA 02144
Phone: 617-628-2160
Fax: 617-628-8237

Permission to Discuss and Share Protected Health Information

*Note: Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient Name: _____Date of Birth: _____

I give permission to Somerville Family Practice (SFP) to VERBALLY discuss the following medical and billing information about me (check all boxes that apply):

☐ Scheduling/appointment information

☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan. This may also include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDs testing and treatment, pregnancy testing, prenatal care, birth control and family planning.

☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan

☐ Chemical dependency information, including my symptoms, diagnosis, medications, and treatment plan

☐ Lab/test results

☐ Billing and payment information

☐ Other: _____

SFP has my permission to discuss the above information with:

Name: _____ Phone: _____

Relationship to Patient: _____

I understand that I may cancel this permission at any time (by writing to SFP), but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

Signature: _____ Date: _____

This authorization expires:

☐ When I cancel it in writing

☐ _____ (specify date) If no expiration date is specified, this authorization will remain in effect until SFP receives written notice to cancel it.

☐ I decline permission to verbally discuss medical information.

_____ _____ _____
Signature of patient/guardian Date Relationship to patient

_____ _____ _____
Witness if patient is unable to sign Date Reason patient is unable to sign

* If an authorized representative, please sign and attach copies of supporting legal documentation.

*Note: A minor patient's signature is REQUIRED (for ages 13 and above) for us to share information about care for (1) conditions relating to the minors sexuality including, but not limited to: family planning and sexually transmitted diseases (2) alcoholism and/or drug abuse; and (3) mental health conditions.

SFP knows that privacy regulations have an impact on our patient relationships, especially when it comes to discussing information about you with family, friends, and others you designate who are involved in your care. We have established a process that allows you to tell us who we may talk with about your medical care. This includes appointment scheduling information, lab and test results, treatment information and billing information.

How can I give others permission to get verbal information about me? Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

How is the information on the form used? Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information before we will share the information.

What are some examples of when this might be useful?

- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parents appointment time

Can the person I designate also get copies of my medical records? No, they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization form available at our clinics or website somervillefamilypractice.net

What if I change my mind? You can change or revoke (stop) this process at any time by writing to us at the address shown below. Forms are available at your clinic.

What happens if I don't complete this form? We will continue to protect your private health information as required by law.

Where do I send the completed form or any changes?
Mail to:
Somerville Family Practice
1020 Broadway
Somerville, MA 02144
Phone: 617-628-2160
Fax: 617-628-8237