UT ERLANGER NEUROSURGERY & SPINE
DISCLOSURE OF PROTECTED HEALTH INFORMATION

Pt Name: _____ **DOB:**_____

According to office policy, test results or release of medical information will be provided to the patient only. Please specify below to whom information may be released to other than the patient.

☐ Patient only

☐ Spouse - Name: _____

☐ Children - Name(s): _____

☐ Other (state relationship) - Name: _____

☐ Doctors Office: _____

May we leave messages at your: (list all that apply)

☐ Home Answering Machine # _____

☐ Cell Phone # _____

☐ Work Voice Mail # _____

☐ Email Address: _____

☐ Other (please specify) # _____

Please chose one method that our auto attendant may leave your Appointment Reminders.

☐ Text to cell phone ☐ Message to telephone ☐ None

I have received a copy of Erlanger Health Systems Privacy Notice explaining the uses and disclosures of my health information:

☐ **Yes** ☐ **No** **Patient Initials**: _____

NOTICE REGARDING PRESCRIPTION REFILLS

Please note that the patient must call in requests for refills of prescription pain medication personally. Requests **must** be made during normal business hours.

Please sign your name to verify permission for all information above.

Patient Signature: _____ Date: _____