Sonoma County Indian Health Project, Inc.
Permission for Communications Form

Print Patient Name:____ DOB:_____________ MRN:_____________

I permit Sonoma County Indian Health Project, Inc. (SCIHP), their physicians, nurses and other personnel ("Health Care Providers") to discuss my confidential health information, in person or by telephone, with the following family members, friends or others involved in my medical care: (List person's name and state the person's relationship to the patient).

Name	Relationship	Phone Number

In addition to the above, this authorization also allows the above named person(s) to:

□ Schedule and/or Cancel appointments for the following department(s):

□ Medical □ Behavioral Health □ Dental □ Other:____________________________________

□ Submit bills to Purchased Referred Care/communicate with PRC (CHS) regarding payment of services

□ Pick-Up and/or Drop off prescriptions to the SCIHP pharmacy

□ Discuss prescriptions with a pharmacist/other pharmacy staff as necessary for my care and treatment

□ Other:____

Release of information under this document is limited to verbal discussions with my health care Provider(s). This document **does not permit release of any written health information to the individuals named above**. A Release of Information Form (ROI) is still required to be completed by the patient in order for SCIHP to release Protected Health Information (PHI).

This authorization is limited to the following time frame from __________ (date) to __________ (date). If no dates are indicated, this form will remain in effect for an unlimited amount of time or until the patient verbally or in writing revokes this authorization.

If at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named about, I must notify my Health Care Provider verbally or in writing.

Signature of patient or legal representative:

Signature:____ Date:________________________________

If signed by someone other than the patient, please ***PRINT*** the following information and your legal relationship to the patient:

Name:____ Relationship to Patient:_________________

Witness:____ Date:________________________________

Permission to Verbally Discuss Protected Health Information: Information Sheet

SCIHP knows that privacy regulations have an impact on our customer service, 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 Release of Information Form (ROI) available at our clinic, by calling HIM Department at 707-521-4540 or at www.scihp.org

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.

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:

Sonoma County Indian Health Project, Inc. (SCIHP)
ATTENTION: Health Information Management Department
144 Stony Point Road
Santa Rosa, CA 95401

OR

Fax to: 707-544-4626

Patient Name: ____ DOB:________________ MRN:_____________