PIONEER
PHYSICIANS NETWORK

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

| PATIENT NAME | DATE OF BIRTH | LAST 4 of SS# |
|---|---|---|
| _____ | _____ | _____ |

I hereby authorize Pioneer Physicians Network, Inc. to use and disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and that it may include information relating to AIDs, HIV Infection, behavioral health services, psychiatric care, and treatment for alcohol and/or drug abuse. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by Federal Privacy Regulations. I understand that I need not sign this authorization to ensure treatment and that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules.

☐ Yes ☐ No - I give permission to the staff and physicians of Pioneer Physicians Network, Inc. to **leave detailed phone messages** at the following number: _____

☐ Yes ☐ No - I consent and state my preference to have the staff and physicians of Pioneer Physicians Network, Inc communicate with me by standard **SMS (text) messaging and email** regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that standard SMS messaging and email are not a confidential method of communication and may be insecure. I further understand that, because of this, there is a risk that standard SMS messaging and email regarding my medical care might be intercepted and read by a third party.

☐ Yes ☐ No - I give permission to the staff and physicians of Pioneer Physicians Network, Inc to **share protected health information** with designated individuals. If yes, please list individuals below and indicate the type of information that can be disclosed.

| Name | Relationship To Patient | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |

**Information to be disclosed:**

☐ **ALL CATEGORIES** ☐ Laboratory Results ☐ Radiology Images ☐ Billing
☐ Discharge Summary ☐ Progress Notes ☐ Referral Information
☐ History and Physical Examination ☐ Radiology Results

I certify that I have read the provisions of this authorization, understand the content, and agree to the terms set forth within the authorization. I understand that this authorization is valid for one year from signature date unless there is a Power of Attorney or Durable Healthcare Power of Attorney on file in my record.

_____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
Patient Signature Date