PATIENT COMMUNICATION CONSENT FORM

Under federal HIPAA law, RRTHS may not release any information pertaining to my medical appointments or medical history to any individual, without my express written permission. By completing this form, I authorize the individuals listed below to:

- Schedule, reschedule or cancel appointments on my behalf.
- Accompany me into my appointment with my provider.

THIS FORM DOES NOT AUTHORIZE ANY INDIVIDUALS TO REQUEST COPIES OF MY MEDICAL RECORD.

Name	Relationship to Patient	Phone Number
		(_____) _____-_____
		(_____) _____-_____
		(_____) _____-_____

By my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent Form. I understand that this form is **not** used for obtaining medical records. I understand that this form allows authorized individuals to accompany me to my appointments & schedule appointments on my behalf.

I understand that I may revoke this consent at any time. Otherwise, this authorization will expire one year from the date signed.

_____ _____

Patient Name Printed Date

_____ _____

Patient/Authorized Signature Relationship to Patient

Office Use Only:	Date received:	Receiving Employee:

PCC LABEL