# SHEPHERD'S CARE MEDICAL CLINIC

**304B Pony Rd., Zebulon, NC 27597**
**919-404-2474 Fax: 919-404-2475**

## PROTECTED HEALTH INFORMATION DESIGNATION FORM

Patient Name_____ MR#_____

You may give Shepherd's Care Medical Clinic written authorization to disclose your protected health information (PHI) to anyone you designate and for any purpose.

Please complete the questions below. Only provide information which you consider acceptable as a means of contacting you and your designated contacts. In the case of a serious medical emergency or in cases otherwise permitted or required by law, this written authorization will not be necessary. Please see Notice of Privacy Practices for details.

You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing PHI about you.

My Home Phone Number: _____ OK to leave message on voice mail? Yes/No

My Work Phone Number: _____ OK to leave message on voice mail? Yes/No

My Cell Phone Number: _____ OK to leave message on voice mail? Yes/No

My e-mail: _____ OK to leave message on voice mail? Yes/No

My mailing address for test results, appointments, billing issues:

_____
Street Address

_____ NC _____
City State Zip Code

At my request, I authorize Shepherd's Care Medical Clinic to disclose my protected health information (PHI) to:

Name _____ Phone Number _____

Street Address_____

City _____ State _____ Zip Code _____

Relation ship to Patient: _____

Specific Information you would like them to know OR not know: _____

_____

_____

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_____ _____
**Patient/Legal Guardian/Power of Attorney's Signature** **Date**