UNIVERSITY OF ROCHESTER MEDICAL CENTER

STRONG HEALTH

AMBULATORY CARE
INVOLVEMENT IN CARE DISCUSSIONS FORM
(Reference HIPAA Policy 0P23.2)

Patient Name: _____ Medical Record #: _____

URMC/Strong Health _____ (department, provider or practice name) may discuss protected health information, including lab/test results and payment issues with the following people:

Name	Relationship	Comments

COMMUNICATION REQUESTS: **Date: _____**

Y	**N**		
		Phone me using the following number.	(#) _____.
[]	[]	May phone at work.	(#) _____.
[]	[]	May leave messages on answering machine.	
[]	[]	Other: _____	

This will remain in effect until notified differently by the above patient.

Note: This Discussion Form is a worksheet to facilitate communication. It does not require the patient's signature. It is not meant to replace or be used instead of the SMH/HH 48 Authorization for Release of Medical Information.

Created:5/30/03
Revised: 08/03