PORTER PHYSICIANS SERVICES, LLC

PRIVACY DISCLOSURE INFORMATION AUTHORIZATION

I,_____, have been offered or received the Privacy Notice for Porter and signed the authorization for the following:

Please list below whom we can speak with and release information to:
(Please understand a Medical Records release will need to be signed)

Family or Friend Name	Relationship to the Patient	Phone Number	Leave Messages and Speak with:	Review Your account with:	Ok to Pick up prescriptions, orders and Medical Records:

I allow messages to be left on the telephone number I provided on the patient information form.
___Yes ___No

Signature _____ **Date**_____

Relationship to the Patient: _____

Refusal of above _____ **Date** _____

Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this portion and return it to the registration clerk or your nurse. All of the communication accessibility aids and/or services that you need are <u>free of charge to you</u>.

Do you think you need any of the following aids and/or services	**□ Yes □ No**
American Sign Language Interpreter	**□ Yes □ No**
Oral Interpreter	**□ Yes □ No**
TTY/TDD	**□ Yes □ No**
Hearing-aid compatible telephone receiver with volume control	**□ Yes □ No**
Television closed captioning	**□ Yes □ No**
Written/printed material in Braille (if available)	**□ Yes □ No**
Written/printed material in other formats (Large print, audio, accessible electronic or other formats as available)	**□ Yes □ No**

Signature _____ **Date**_____