Designated Individuals' Authorization

(HIPAA Compliance)

In order to protect your patient confidentiality, we need to know if there is a phone number (with voicemail) for you where we can leave the results of your laboratory tests or other sensitive information. Please indicate the information below, and we will keep this in your file until you instruct us in writing to remove it.

I give LifeWay Health employees permission to leave confidential health care information for me at the following phone numbers(s):

____ (if none, please note)

____ (if none, please note)

____ (If none, please note)

I understand these numbers will be used until I notify LifeWay Health in writing if they should no longer be used.

I authorize the following people to receive information regarding my medical status (including access to my medical records) and financial records ongoing.

Name ______________________ Relationship _____________________ Phone ______________________

Name ______________________ Relationship _____________________ Phone ______________________

Name ______________________ Relationship _____________________ Phone ______________________

Name ______________________ Relationship _____________________ Phone ______________________

Name ______________________ Relationship _____________________ Phone ______________________

Signature: ____ **Date:** ___________________