Johnson Memorial Health
1125 West Jefferson St., PO Box 549
Franklin, IN 46131

The terms "Johnson Memorial Health" and "JMH" and "Hospital" include: Johnson Memorial Hospital; and Johnson Memorial Health (and the Departments and Centers of the Hospital including Employed Physician Practices) and Johnson Memorial Immediate Care & Occupational Health Center.

HIPAA Privacy Authorization

Authorization for Use and Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act (HIPAA) – 45 CFR Part 160 and 164

Johnson Memorial Health (hospital and/or hospital outpatient clinics):

☐ Hospital	☐ Immediate Care & Occupational Health	☐ Comprehensive Pain Services
☐ Oncology	☐ Podiatry	☐ Pulmonary Clinic
☐ Therapy	☐ Wound Healing & Vascular	

Johnson Memorial Health Physician Network (JMH physician offices):

☐ Family Medicine	☐ Internal Medicine	☐ Gastroenterology	☒ Orthopedic Surgery/Sports Medicine	☐ Pediatrics	☐ Surgical Specialists	☐ Women's Health (OB/GYN)

I understand that I am entitled to a copy of the Johnson Memorial Health's Notice of Privacy Practices.
I can access a copy of the Notice of Privacy Practices from the JMH website or from a hospital representative.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

By signing this document, I acknowledge that I have read, understand and may request a copy of this HIPAA Privacy Authorization form, and I further acknowledge that a copy of the Hospital's Notice of Privacy Practices has been made available to me.

I understand that I may change or update the list below as needed, as it describes who may receive confidential information regarding my financial bills and who may speak with my Medical Providers regarding my clinical care.

Telephone Consumer Protection Act:

I expressly consent to allow JMH, it's agents, and those Providers of professional goods or services that provided or assisted in treatment, to contact me by use of an automated telephone dialing device and to leave automated or pre-recorded voice messages, send text messages, send short message service alerts (SMS), or send me email messages. When designated, JMH may contact me regarding my appointment, exam confirmations, reminders, wellness checkups, hospital pre-registration instructions, pre-operative instructions, LAB results, post-discharge follow-up intended to prevent readmission, prescription notifications, home healthcare instructions, treatment, notification that certain medications or other products or services being provided to me are ready for pick up, communicate to me about my account, or communicate with me regarding the collection of any money that I may owe JMH or those Providers of professional goods or services that provided or assisted in treatment, or related to treatment provided to me, my child or a person to whom I am a guardian.

I agree that this prior express written consent shall also extend to any third party that is servicing my account on behalf of JMH or those Providers of professional goods or services that provided or assisted in treatment, or who are attempting to collect any money due regarding my account on behalf of JMH or associated Providers. This consent also includes telemarketing of future goods and services to me by those parties described herein. My express consent includes contact to my listed telephone numbers and/or email address, plus any other telephone numbers to which I may become a subscriber or regular user in the future.

Messages and Electronic Communication Consent:
I agree that Johnson Memorial Health (JMH) may communicate with me via voice mail and/or personally on phone number(s) below. By providing my contact phone number(s) in this section, I authorize JMH to contact me via the following means of communication.

Home Phone # _____ Mobile Phone # _____

If unable to reach me (please check one):

____ **Yes, y**ou may leave a ***DETAILED*** **voicemail message** regarding normal test results, appointments, medication, billing, etc.

___ Home ___ Mobile Phone

____ **Yes,** you may leave a ***GENERIC*** **voicemail message** and ask me to return your call.

___ Home ___ Mobile Phone

____ **Yes,** you may speak with someone that may answer my phone and leave a ***GENERIC*** **message** and ask me to return your call.

____ **DO NOT leave any message** on my answering machine or voicemail and **DO NOT** speak to anyone that may answer my phone. I prefer that my doctor or staff speak to me personally regarding any medical information, appointments or billing needs.

Designee(s) List

Notes:

- This list must be updated annually for physician offices and other clinics.
- This list must be completed for each hospital visit and/or service. (Inpatient, Outpatient, Laboratory, Radiology, etc.)

I acknowledge that I have the right to authorize access and/or verbal disclosure of my Protected Health Information (PHI) to anyone I choose. This data may include: billing; condition; treatment; and prognosis of my condition.

This information may be released to the following individual(s). I may update this list by giving written consent to JMH.

Please check the applicable box indicating if we may discuss your health status and/or financial (bill) matters with your Designee(s) below. ***Note, the information shared will only be for the dates designated by you.***			Discuss **Health Status** with my Provider	Discuss **Financial Billing** Information
Relationship	**Name:**	**Phone #**	☐ YES ☐ NO	☐ YES ☐ NO
Relationship	**Name:**	**Phone #**	☐ YES ☐ NO	☐ YES ☐ NO
Relationship	**Name:**	**Phone #**	☐ YES ☐ NO	☐ YES ☐ NO

Unless otherwise revoked, this authorization shall be in full force & effect for the next 12 months following the date & signature indicated below, for each designated JMH physician office. (each visit for hospital accounts)

If I wish to limit or restrict the release of any confidential information, I must submit a written request to the JMH Medical Records Department or a designated JMH Physician Office.

_____ _____ _____ _____

Signature (Patient or Authorized Representative) Date Time Signee Relationship

Reason patient unable to sign:
☐ Incapacitated ☐ Restraints ☐ Other:_____

_____ _____ _____

JMH Witness Date Time