SOUTHERN HILLS FAMILY MEDICINE OF BRENTWOOD
SHANNON C. MCDONALD, M.D.

May Southern Hills Family Medicine and/or members of the office staff release medical information to specified persons other than you? __________ Yes __________ No.

If yes, please specify to whom this information may be released.

Authorized Person Relationship to you

____

____

____

Please check the information that may be released

O Appointments
O Medications
O Financial/Billing

I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office, which contain my health history, symptoms, examination test results, diagnoses and treatment plans to be used as a basis for planning my care and treatment and that this information may be released to other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that my physician keeps on premises a copy of the “Notice of Privacy Practices for Protected Health Information” which provides a more complete description of the used and disclosures of my consent and that a written copy will be provided to me on request.

I understand that my physician has the right to change this policy and that I will be notified in writing prior to any changes taking effect.

I understand that this document is a part of my permanent medical record and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.

____________________________ ____________________________

Signature **Date**