

Consent for Access to Protected Health Information (PHI)



Patient Full Name: _____ Date of Birth: ____/____/____

HomeMD Housecall Services Patient Portal is a HIPAA compliant communication and health record system where you and/or people you authorize can stay updated or access important health information online.

- If you would like to authorize a personal representative to access your health care information and communicate with your HomeMD Housecall Services Provider Team electronically through the HomeMD Housecall Services Patient Portal, please complete the PHI form with the **appropriate information**.
- If you have signed the Consent for Services form yourself and would like to complete the below section to consent to authorizing access to Protected Health Information for those who you want to have access to your medical information and care providers.
 - *This consent applies to health information HomeMD Housecall Services already has about me, information about future care I may receive from HomeMD Housecall Services and information HomeMD Housecall Services receives from third parties. This consent will continue unless I cancel by giving written notice to HomeMD Housecall Services or it expires as required by law. Cancellation will apply **after the date** when the notice to cancel is received. It will not affect information that used or disclosed before cancellation.*
- **If you are the Legal Representative** for someone who is not able to consent for themselves, you will need to fax or email this form **and the supporting legal documents** (Health Care Directive, Healthcare Power of Attorney forms, proof of guardianship, etc.) to our office as soon as possible. **Receiving this paperwork is the only way we can provide access to Protected Health Information to someone other than the patient.**
 - **If the Legal Representative is signing this form:** I acknowledge and agree that by signing this form as a Legal Representative for the patient, I swear and attest that I am legally authorized to act and make decisions on behalf of the patient. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative to receive related communications. Upon signing the form or any other required documentation from HomeMD Housecall Services as a Legal Representative for the patient, I hereby release and hold harmless HomeMD Housecall Services and its representatives from any claims or damages arising from HomeMD Housecall Services reliance on my attestation that I am Legal Representative.

People who the signer of this consent grants access to:

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

REQUIRED: By signing below, you acknowledge the above and that you are giving the following individuals access to your health care records maintained by HomeMD Housecall Services, including updates on your health care status.

Patient signature: _____ Date: _____

Legal Representative Signature *(if authorized to sign for patient)*: _____ Date: _____

Legal Representative printed name: _____ Relationship to patient: _____

Return via fax to the number listed below or use our secure upload feature on our website at www.homemdhealth.com.