Name:____________________
DOB:______________________

Patient Name: ____

Date of Birth: _______/______/_______ Today's Date: ______/______/_______

PRESCRIPTION HISTORY CONSENT

I authorize Lake Health Physician Group to obtain my prescription history from an external source.

X ____ Date: __________ Time: __________
Patient or Legal Guardian Signature

CONSENT FOR COMMUNICATION REGARDING MY HEALTH (Adult Patients Only)

I hereby authorize Lake Health/Lake Health Physician Group to discuss protected health information with a family member, guardian or friend listed below. This includes information related to the care or changes to the care that I have received. ***This does not authorize requests for copies of medical records. An "Authorization for Disclosure of Health Information" must be completed when requesting copies of medical records.***

1. Name: ____ Relationship: ____________________
   Phone Number: ____
2. Name: ____ Relationship: ____________________
   Phone Number: ____

CONSENT FOR COMMUNICATION REGARDING A MINOR (Pediatric Patients Only)

This consent authorizes Lake Health/Lake Health Physician Group to discuss protected health information with a family member, guardian or friend listed below. This includes information related to the care or changes to the care that a minor has received. ***This does not authorize requests for copies of medical records. An "Authorization for Disclosure of Health Information" must be completed when requesting copies of medical records.***

1. Name: ____ Relationship: ____________________
   Phone Number: ____
2. Name: ____ Relationship: ____________________
   Phone Number: ____

THE FOLLOWING INDIVIDUAL(S) MAY BRING MY CHILD IN FOR TREATMENT IN MY ABSENCE
Note: This Authorization Does NOT Grant Access to Medical Records.

1. Name: ____ Relationship: ____________________
   Phone Number: ____
2. Name: ____ Relationship: ____________________
   Phone Number: ____

MINORS (16-18 YEARS) PRESENTING WITHOUT A PARENT OR GUARDIAN

☐ I give permission to Lake Health/Lake Health Physician Group to provide medical care to my child (examinations, immunizations, laboratory tests, radiology tests, prescribe medications).

☐ I do not give permission to Lake Health/Lake Health Physician Group to provide medical care to my child (examinations, immunizations, laboratory tests, radiology tests, prescribe medications).

Name:______________________
DOB:_______________________

CONSENT FOR TELEPHONE, EMAIL, AND/OR TEXT MESSAGE COMMUNICATIONS

I hereby authorize Lake Health/Lake Health Physician Group to communicate the following protected health information contained in my medical record with me via the following forms of communication (check where applicable):

☐ Home Phone (_______) ________ - ____________
- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ Work Phone (_______) ________ - ____________
- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ Cell Phone (_______) ________ - ____________
- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ E-mail ____ @ ______________________

I understand that voicemail, e-mail, and text messages are not a confidential method of communication. I further understand that there is a risk that voicemail, e-mail, and text communications between myself and Lake Health/Lake Health Physician Group regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I understand that Lake Health/Lake Health Physician Group is not responsible for e-mail or text messages that are lost due to technical failure during composition, transmission, and/or storage. I also understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail or text messaging.

This authorization shall be in force and effect for twelve (12) months from the date of signature. 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.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may no longer be protected by federal or state law.

THESE CONSENTS AND AUTHORIZATIONS ARE VALID FOR TWELVE (12) MONTHS FROM THE DATE OF SIGNATURE BUT MAY BE REVOKED BY NOTIFYING LAKE HEALTH IN WRITING AT ANY TIME. I UNDERSTAND THE NATURE OF THIS CONSENT AND IT IS REVOCABLE AT ANY TIME.

Patient/Legal Guardian Signature: ____________________________ Date: __________ Time: __________

Relationship: ____

Witness Signature: ____

An employee of Lake Health may witness this consent; however, the employee is signing this Form as a witness and not as an employee or on behalf of Lake Health.

FOR OFFICE USE ONLY

☐ Entered

__________ ______________
Initials Date