Lifesprk SHINE ON™ Whole Person Senior Care | Health Primary Care

Permission to Communicate with Persons Involved in Member Care

Last Name: _____ **First Name:** _____ **MI:** _____ **DOB:** _____

Lifesprk Health knows that you may not want us to share information with your family and friends who are or are not involved in your care. If you want us to send or share copies of your health records, you will need to fill out a separate authorization form. Because we must protect your health information, even when communicating with those involved in your care, this form allows you to consent or deny our leaving voicemail messages that include health information.

1. Please fill out the second page to tell us what types of information you ***do not want*** released and to whom.
2. Please note: If your medical information includes mental health evaluation and treatment, drug or alcohol use, or HIV/AIDS, Lifesprk Health may discuss those details unless you tell us otherwise here:

   _____

3. We know that you may want Lifesprk Health to leave voice messages for you or the people you name on this form. If so, we want you to understand that leaving a voice messages is not a secure form of communication, because someone who is not authorized to access a voice message may listen to the message on an answering machine or voicemail system. By writing your initials in the space below, you can give us your consent to leave voice messages that may contain your health information. You do not have to give us this consent if you don't want to give it.
4. _____(initials): I understand that voice messages are not a secure form of communication. I give Lifesprk Health permission to leave my personal health information in voice messages.
5. Please read the following statements carefully before you sign the form:
   - This form will remain valid and in effect for as long as you have Lifesprk Health services in place, unless you revoke it.
   - You may revoke this authorization at any time by sending a written statement to Lifesprk Health, Attention Privacy Officer, 5320 W 23rd Street, Suite 130, St. Louis Park, MN 55416. If Lifesprk Health has already shared information based on this form, your revocation will not apply to those discussions.
   - This authorization is voluntary. Lifesprk Health will not condition treatment on whether you sign this form.
   - Once the information covered by this form is released, it may no longer be protected under the state or federal privacy regulations and the recipient might re-disclose the information.

See reverse for exceptions to permissions

Last Name: ____________________ **First Name:** ____________________ **MI**: ______ **DOB:** ____________________

Exceptions to Permissions: I ***do not want*** to release information to the following people.

Relationship	Name and Contact Information	What Information (check all that apply)	Initials
❑ Spouse/partner ❑ Child ❑ Friend ❑ ____________	Name: Address: Phone: Email:	❑ Scheduling and appointment information ❑ Billing and payment information ❑ Medical information, including my health status, medications, and plan of care ❑ All of the above	
❑ Spouse/partner ❑ Child ❑ Friend ❑ ____________		❑ Scheduling and appointment information ❑ Billing and payment information ❑ Medical information, including my health status, medications, and plan of care ❑ All of the above	
❑ Spouse/partner ❑ Child ❑ Friend ❑ ____________		❑ Scheduling and appointment information ❑ Billing and payment information ❑ Medical information, including my health status, medications, and plan of care ❑ All of the above	
❑ Spouse/partner ❑ Child ❑ Friend ❑ ____________		❑ Scheduling and appointment information ❑ Billing and payment information ❑ Medical information, including my health status, medications, and plan of care ❑ All of the above	

____ ____________________

Patient or Legal Representative Signature **Date**

____

Legal representative printed name and authority to sign for member
(i.e. Health Care Directive, Medical POA - please include documentation)