AMBULATORY CARE
INVOLVEMENT IN CARE DISCUSSIONS FORM
(Reference HIPAA Policy 0P23.2)

Patient Name: __________________________ Medical Record # __________________

URMC/Strong Health ____________________________ (department, provider or practice name) may discuss protected health information, including lab/test results and payment issues with the following people:

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<th>Name</th>
<th>Relationship</th>
<th>Comments</th>
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COMMUNICATION REQUESTS:  

Date: __________

Y  N

☐  ☐ May phone at work.  (#) ____________

☐  ☐ May leave messages on answering machine.

☐  ☐ Other: __________________________

This will remain in effect until notified differently by the above patient.

Note: This Discussion Form is a worksheet to facilitate communication. It does not require the patient’s signature. It is not meant to replace or be used instead of the SMH/HH 48 Authorization for Release of Medical Information.