AUTHORIZATION FOR COMMUNICATION OF
PROTECTED HEALTH INFORAMTION

Patient Name (print) Date of Birth Chart Number

It is frequently necessary for personnel at this practice to communicate lab results, instructions, information about treatment, payment and other items of protected health information with our patients. It is frequently not possible to speak personally with the patient to leave this information. In the event that our personnel are not able to speak with you (the patient) directly, Please give us instructions about communicating it to you.

1. Messages may be left on my home answering device @ _____

2. My home answering device does not identify me by name, but it is appropriate to leave messages for me there (circle) Yes or No

3. Messages may be left for me on my Cell voicemail @ _____

4. Messages may be left for me on my Work phone Voicemail @_____

5. Messages may be communicated to me via email @_____

6. Messages may be left for me with my partner (name)_____

7. Other Person(s) authorized to receive messages on my behalf:

   Name_____@_____

   Name_____@_____

I hereby release, Discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time.

Signature of Patient/ Guardian_____ Date_____

Relationship to patient if Minor_____