Authorization for Verbal Communication and/or to Leave Voice Mail Messages Regarding My Personal Health Information

Patient Information

Name- Last, First, MI	Date of Birth:

Information to be disclosed: verbal communication only regarding patient's care-no copies of medical records provided
Please Provide your current telephone numbers

Home Phone	Cell Phone
Work Phone	Other Phone

We normally contact our patients between 8 a.m. and 5 p.m. Monday through Thursday and 8 a.m. to 3 p.m. on Friday. Please ***check below*** where you would prefer to be contacted during these hours.

Home Phone ______________ Cell Phone ________________ Work Phone ________________ Other Phone _____________

If we need to reach you after hours, please ***check below*** where you prefer to be called:

Home Phone ______________ Cell Phone ________________ Work Phone ________________ Other Phone _____________

Your Protected Health Information Designees:
If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information {e.g. lab or test results, prescription information). This person (designee) will also be able to call the office on your behalf.

Please print the name and relationship to you/patient of each designee below: ____

Designee Name:	Phone number:	Relationship to Patient:
Designee Name:	Phone number:	Relationship to Patient:
Designee Name:	Phone number:	Relationship to Patient:
Designee Name:	Phone number:	Relationship to Patient:

_______ Check here if you ***do not want*** your health care information discussed with anyone other than yourself.

Confidential Voice Mail:
Please ***check below*** where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) blank if you ***do not wish*** to receive voice mails.

Home Phone ______________ Cell Phone ________________ Work Phone ________________ Other Phone ____________

Email Address:____

Your signature ***below*** confirms your approval of these updated HIPPA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

____ ___________
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE SIGNED

Verbal Communication Only. This authorization allows for verbal communication {both in person and on the telephone between and the designated person(s) on this form. It does not allow for copies of medical records to be released.
Voice Mail Messages : Providers and their staff recognize confidentiality as a very important part of your relationship with them. To protect your confidentiality, they will not routinely leave messages on your personal messaging system (voice mail or answering machine or with your spouse, family members or any other individual) unless you specifically give your permission to do so. This authorization may be used to share this information in the manner that you specify.