

Permission to Disclose Protected Health Information to those Involved in the Patient's Care and for Notification Purposes

Patient Name _____ Date _____

Date of Birth _____ MR#: _____

The following individuals can be given information about my health, well being, care and/or payment related to my care.

1. Father and Mother _____

2. Spouse _____

3. Significant Other _____

4. Any Specific Person _____

5. I may be contacted by mail regarding my health:
YES or NO

6. You may leave a message on my answering machine or voice mail:
YES or NO

7. If you answered "yes" to question 6 at what telephone number(s) may we contact you?

8. The following information may be given or left on answering machine: Circle all that apply.

- a) Appointment date and time
- b) Test/lab results – negative/normal results
- c) Medications
- d) We may contact your employer concerning insurance denials and additional information for filing a medical claim

9. Preferred method for reminder calls and other electronically generated messages. Please choose one and include correct number:

Phone Call _____ **OR** Text Message _____

10. I would like a printed copy of the Notice of Privacy Practices:
YES or NO

Signature _____

Date _____

Witness _____

Date _____

Revised 01/2020