CENTRAL INDIANA ALLERGY
www.ciallergy.com

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

Signature_____ Date_____

Witness_____ Date_____

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