

Patient Contact Authorization

Patient name _____ Date of Birth _____

In an effort to reach you more efficiently to confirm appointments, leave messages regarding you healthcare and to discuss insurance billing issues, we are asking you to complete the following telephone contact information.

While we prefer NOT to leave messages, we would like to insure that your medical information is properly protected as required by HIPAA guidelines. By completing the following telephone contact information this will give us your authorization to leave messages with those individuals listed at the numbers given below, if applicable. We will not leave messages containing sensitive health related information.

Please complete the below contact information:

Home _____ Cell _____

Work _____ Email _____

Please list the names of family or friends with whom you authorize us to leave messages relating to your medical care.

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

Please list the name and telephone number of your pharmacy.

_____ Telephone _____

By signing below I authorize my physician or their representatives to leave messages in reference to my appointments, billing issues, prescriptions and test results on my voice mail or with the individuals listed above in the event I am not available.

Patient/Guardian _____ Date _____

Witness _____ Date _____