In compliance with HIPAA, (Health Insurance Portability and Accountability Act), our office must obtain written permission to leave a message on your home answering machine/voicemail or to disclose any medical or billing information to anyone other than you, the patient. Please sign below giving or denying permission for our office to leave messages on your answering machine or with a person other than yourself.

NAME, (PLEASE PRINT) _____, Date of birth_____

Check all that apply

_____ I give permission for a message to be left on my answering machine or voicemail regarding either my medical or billing information.

_____ I give permission for you to contact me by using the email address I have provided, regarding either my medical or billing information.

_____ I give permission for my medical information to be disclosed to:

_____, Relationship_____
(PLEASE PRINT name of spouse, child, parent, etc.)

_____ I give permission for my billing information to be disclosed to:

_____, Relationship_____
(PLEASE PRINT name of spouse, child, parent, etc.)

OR

_____ I deny any information to be released to anyone other than myself.

SIGNATURE_____ DATE_____