HIPAA Consent Authorization to Call or Leave Messages Authorization to Release Information

The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care. In accordance with HIPAA regulations, we require your authorization in writing at what phone numbers we may call you, your permission to leave detailed messages, and your authorization for us to call or leave medical information with other persons.

Patient Name: _____ **Date of Birth:** _____

Patient Phone Number(s):	Phone Type (Home, Cell, Work)	Please check box if okay:
_____ (Preferred)	_____	o Okay to leave detailed message
_____ (Alternative)	_____	o Okay to leave detailed message
_____ (Alternative)	_____	o Okay to leave detailed message

I authorize that you may call and share my information with the following person(s) :

Other Phone Numbers:	Name/Relationship:	Please check box if okay:
_____ (Preferred)	_____	o Okay to leave detailed message
_____ (Alternative)	_____	o Okay to leave detailed message

I understand my HIPAA rights and I authorize this office to communicate with myself or others via telephone as indicated above. I understand I may revoke this authorization in writing at any time.

_____ _____

Signature of Patient / Responsible Party Date