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Authorization for Verbal Communication and/or to Leave Voice Mail Messages

Please print your full name and provide your current telephone numbers.	
Patient Name (Last, First, MI):	Date of Birth:
Home Phone:	Cell Phone:

Verbal Communication: This authorization will allow us to verbally discuss {in person and on the phone} your medical information {e.g. lab results, test results, prescription information, instructions, etc} with individuals you designate. This person will also be able to call the office on your behalf.

In the boxes below, please list the person(s) with whom we may discuss your medical information {e.g. lab results, test results, prescription information, instructions, etc}. If patient is a minor, list the names of both parents. (Note: Michigan law allows both parents access to medical information, unless prohibited by court order. If you have a court order prohibiting information from being shared with an individual, please provide a copy of the order to our office, otherwise, the other parent must be listed.)

_____ Check here if you ***do not want*** your health information discussed with anyone other than yourself. If you choose this option, we will only relay a message for you to call our office.

Designee Name:	Phone number:	Relationship to Patient:
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Designee Name:	Phone number:	Relationship to Patient:

Voice Mail Messages: We recognize confidentiality as a very important part of your relationship with our office. We will not routinely leave messages on your voicemail unless you give your permission to do so.

_____ Check here **to give us your permission** to leave a voice mail with lab results, test results, prescription information, instructions, etc. We will only leave a voicemail on your home or cell phone, we will not leave confidential information on a work phone.

_____ Check here if you **do not want** us to leave a voicemail with lab results, test results, prescription information, instructions, etc. If you choose this option, we will only leave a voicemail asking you to call our office.

Your signature ***below*** confirms your approval of these updated HIPAA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

_____ _____

Signature of Patient (or Parent/Legal Guardian) Date