Patient Authorization

I understand that my Protected Health Information is as follows:
Information that is oral or recorded in any form that relates to my past, present, or future , physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.
I understand that under the Health Insurance Portability & Accountability Act of 1996 “HIPAA” I have certain rights to privacy regarding my protected health information.
I specifically give this Health Care Provider authorization to use a particular phone number to leave a detailed message pertaining to lab results and referring appointment information.

* Required

1. **NAME** *

2. **Home Phone**

3. **Cell Phone**

4. **Other Phone**

5. **Please list any persons, other than your doctor, with whom we may discuss your private health information or financial matters.** *

6. **Patient Electronic Signature** *