Patient Communication Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply):

Text/SMS:

☐ O.K. to text appointment reminders to your cell phone

Home Telephone:

☐ O.K. to leave message with detailed information

☐ Leave message with call-back number only

Work Telephone:

☐ O.K. to leave message with detailed information

☐ Leave message with call-back number only

☐ Do not call me at work

Written Communication

☐ O.K. to mail to my home address

☐ O.K. to fax to my home fax:

☐ O.K. to email:

☐ OTHER: ____

Would you like to receive our electronic newsletter?

☐ yes ☐ no

May we send you a customer service satisfaction survey? ☐yes ☐ no

Please indicate any other family members with which you would like us to be able to communicate health, insurance, and/or financial information relating to your hearing health care.

Name: ___________________________________ Phone # ______________________

Relationship: ______________________________

Name: ___________________________________ Phone # ______________________

Relationship: ______________________________

Patient Signature:____________________________Date:____________________________

☐ Patient Refused to sign

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In case of emergency, please contact: Name:______________________________Relationship:_____________

Home Number:__________________Cell Number:__________________