HIPAA/PATIENT CONTACT CONSENT

Patient (Last Name)          (First Name)       (M.I)             Date of Birth (MM/DD/YYYY)

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

☐ Home telephone: (    ) ________ - __________________
☐ Work telephone: (    ) ________ - __________________
☐ Cell phone:          (    ) ________ - __________________

May we mail a recall appointment reminder to your home?       Yes _____ No _____

May we mail test results to your home?                         Yes _____ No _____

May we leave appointment information on your answering machine/voice mail?       Yes _____ No _____

May we leave billing information on your answering machine/voice mail?       Yes _____ No _____

May we leave medical information on your answering machine/voice mail?       Yes _____ No _____

When available, would you like to be able to contact the office through secure electronic messaging via email?       Yes _____ No _____

If yes, what is your email address: _________________________________

I give permission to share appointment, billing or medical information with the following persons named below:

Appointment information: _________________________________
Billing Information: _______________________________________________________________________
Medical information : _____________________________________________________________________

Signature of Patient / Parent or Legal Guardian    Date

Revised 10/8/2014