

Voice-Mail Authorization

I recognize that timely delivery of results of tests or other communications of health care information is important to the delivery of quality health care. I understand that there may be times when it is more efficient and/or effective to receive information telephonically. In order to allow for the free-flow of such information, the following acknowledgement is executed.

My signature below acknowledges that it is permissible for members of this practice to communicate medical information to me by calling me at the following number: _____ . If I do not answer and a voice mail system or answering machine is initiated, the practice is authorized to leave information related to my medical condition on that voice mail system or answering machine. I recognize that this may mean that others that are in the vicinity of the system or machine or that have access to it may have access to an audio transmission of my private health care information. However, the risk of any such incidental disclosure is so small and/or I do not have such privacy concerns in my household, that the benefits of efficient delivery of my healthcare information significantly outweighs any risks involve.

This authorization does not apply to the release of records related to psychotherapy, HIV or drug and alcohol testing, which are subject to more specific protections afforded by state law.

I recognize that I have the right to revoke this authorization at any time by calling the practice. Also, this authorization only allows for such communication that is related to past, present or on-going treatment of me. Any authorizations required by the privacy rule issued as a result of the Health Insurance Portability Act of 1996 ("HIPAA") that are for the release of information to someone other than myself will require a separate authorization form and is not incorporated into this document.

I acknowledge and understand the above:

Signature of Patient/Legal Guardian/Legal Representative

Date

Name of Personal Representative

Relationship to Patient