



## HIPAA Privacy Act

In order to protect your privacy we need YOU to give us PERMISSION to leave a MESSAGE on your answering machine at home or at work or permission to share clinical/medical information with others. Please note that our office will not release any medical information for advertising purposes. This includes information requested to anyone calling into our office that does not have their name included on this form.

\_\_\_\_\_ NO, I DO NOT wish to have any messages or information left on my answering machine at home or at work. (If you check NO!!!! go to the bottom of the page and sign this form)

Please circle yes or no to the following questions:

| HOME |    |  | WORK |    |
|------|----|--|------|----|
| Yes  | No | It is okay to leave a message regarding an appointment time. | Yes  | No |
| Yes  | No | It is okay to leave a message regarding tests results.       | Yes  | No |
| Yes  | No | It is okay for the billing department to leave a message.    | Yes  | No |
| Yes  | No | It is okay to leave a message with my spouse.                | Yes  | No |

You may leave a message or discuss my condition with: \_\_\_\_\_

Phone: \_\_\_\_\_

Patient's Name

Signature of Patient

Today's Date