

Patient Contact Authorization
(Over 18 years)

In general, the HIPPA 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 or that a communication of PHI be made by alternative means.

Patient Name: _____ DOB: _____

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

Cell Phone: _____

OK to leave message with normal lab results

Home Phone: _____

OK to leave message with normal lab results

Work Phone: _____

OK to leave message with normal lab results

Written Communication:

OK to mail to home address

OK to email this address: _____

Alternate Authorized Contacts (OK to disclose normal lab results to other persons):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____