Patient Contact Authorization Form

I. Occasionally, it is necessary for our office to call to discuss insurance information, coordinate/discuss referral to another physician, or schedule/cancel appointments. Law requires your written permission to call.

Name _____ Relationship _____

II. Telephone number(s) where it is permissible for this office to call you.

Number _____

Number _____

Permission to contact you by Email: YES _____ NO_____

*If yes, please note your email address:_____

Permission to leave a message: YES _____ NO _____. If No, please explain why below.

III. Can confidential messages (i.e., messages to call the office regarding appointments) be left on your home answering machine or voicemail?

YES _____ NO _____

IV. Can we call you at your place of employment if you cannot be reached at home?

YES _____ NO _____

V. Would the custodial parent need to be notified if non-custodial parent requests copy of medical records?

YES _____ NO _____ NA _____

VI. Acknowledgement of receipt of Notice of Privacy Practices:

YES _____ NO _____

Patient Name (Print) _____

(Signature) _____

Date _____

Please Circle one - Patient: Self / Guardian / Custodial Parent