



Patient Contact Authorization

In general, the HIPAA 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: _____

Parent/Guardian: _____ Relationship to Patient: _____

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

Home Telephone: _____

- O.K. to leave message with normal results
or
- Leave message with call back number only

Work Telephone: _____

- O.K. to leave message with normal results
or
- Leave message with call back number only

Cell Phone: _____

- O.K. to leave message with normal results
or
- Leave message with call back number only

Written Communication:

- O.K. to mail to my home address
- O.K. to leave test results with:

Name: _____

Name: _____

Signature: _____ Print Name: _____

Date: _____ Account Number: _____