NEWPORT CARDIAC & THORACIC SURGERY

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PERMISSION TO DISCUSS PATIENT HEALTH INFORMATION

Patient Name: ___________________________________ Date of Birth: _____________

In compliance with HIPAA Privacy Laws, we will continue our practice of leaving messages on answering machines or with the person answering the phone regarding appointment reminders or the rescheduling of appointments.

In order to protect your confidentiality, please initial the following items you agree with:

_______ I hereby give my permission for your office to leave messages regarding my medical information on the following voicemail numbers and/or email address:

Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )	Written Correspondence
☐ Leave call back # only. Do not leave message	☐ Leave call back # only. Do not leave message	☐ Leave call back # only. Do not leave message	☐ Mail/Delivery Service
☐ OK to leave detailed message with person	☐ OK to leave detailed message with person	☐ OK to leave detailed message with person	☐ FAX # ( )
☐ OK to leave detailed message on answering machine	☐ OK to leave detailed message on answering machine	☐ OK to leave detailed message on answering machine	☐ Email

______ I hereby give my permission for your office to discuss information about my health care with the person(s) listed below (this includes spouse, children, etc.). Please understand that unless listed below, we will not be able to release information regarding your care to your family members/friends.

NAME / PHONE | RELATIONSHIP

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(   ) _________________________ | _________________________

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(   ) _________________________ | _________________________

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(   ) _________________________ | _________________________

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Signature of Patient, Parent, or Guardian Date