DESIGNATED INDIVIDUALS AUTHORIZATION

(FOR HIPAA COMPLIANCE)

IN ORDER TO PROTECT YOUR PATIENT CONFIDENTIALITY, WE NEED TO KNOW IF THERE IS A PHONE NUMBER (WITH VOICEMAIL) FOR YOU WHERE WE LEAVE RESULTS OF YOUR LABORATORY TESTS OR OTHER SENSITIVE INFORMATION. PLEASE INDICATE THE INFORMATION BELOW, AND WE WILL KEEP THIS IN YOUR FILE UNTIL YOU INSTRUCT US IN WRITING TO REMOVE IT.

I GIVE OUR FAMILY DOCTOR EMPLOYEES PERMISSION TO LEAVE CONFIDENTIAL HEALTH CARE INFORMATION FOR ME AT THE FOLLOWING PHONE NUMBER(S):

____ (IF NONE, PLEASE NOTE)

____ (IF NONE, PLEASE NOTE)

____ (IF NONE, PLEASE NOTE)

I UNDERSTAND THIS NUMBER(S) WILL BE USED UNTIL I NOTIFY OUR FAMILY DOCTOR IN WRITING IF THEY SHOULD NO LONGER USE.

I AUTHORIZE THE FOLLOWING PERSONS TO RECEIVE INFORMATION REGARDING MY MEDICAL STATUS (INCLUDING ACCESS TO MY MEDICAL RECORDS) AND FINANCIAL RECORDS ONGOING:

NAME ____________________________ RELATIONSHIP ______________ PHONE _______________

NAME ____________________________ RELATIONSHIP ______________ PHONE _______________

NAME ____________________________ RELATIONSHIP ______________ PHONE _______________

NAME ____________________________ RELATIONSHIP ______________ PHONE _______________

NAME ____________________________ RELATIONSHIP ______________ PHONE _______________

SIGNATURE ____ DATE ___________________________

EMAIL COMPLETED/SIGNED FORM TO: info@ourfamilydoctorasheville.com