

PATIENT INFORMATION AUTHORIZATION

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). Completion of this form tells us your preferences with regard to telephone messages and whom you give authorization for our office to speak with on your behalf. Further authorization may be needed under more specific circumstances.

I wish to be contacted in the following manner (CHECK ALL THAT APPLY):

- | | |
|---|--|
| <input type="checkbox"/> Home Telephone: _____ | <input type="checkbox"/> Written Communication: |
| <input type="checkbox"/> O.K. to leave detailed message * | <input type="checkbox"/> O.K. to mail to my home address |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> O.K. to mail to my work address |
| | <input type="checkbox"/> O.K. to fax to: _____ |
| <input type="checkbox"/> Work Telephone: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> O.K. to leave detailed message * | _____ |
| <input type="checkbox"/> Leave message with call-back number only | _____ |

* Either with any individual, other than yourself, whom answers the phone or on an answering machine.

Other individuals I authorize to take messages or receive my Protected Health Information are (check and list all that apply):

- Spouse** (Name) _____
- Relative** (Name/Relationship to you) _____
- Relative** (Name/Relationship to you) _____
- Relative** (Name/Relationship to you) _____
- Other** (Name/Relationship to you) _____

I authorize Diablo Valley Oncology and Hematology Medical Group, Inc. to use my Protected Health Information per my instructions above.

X _____	_____	_____
Signature of Patient	Date	Witness

