CONSENT TO LEAVE VOICE OR TEXT MESSAGES

Completion of this document authorizes the disclosure and/or use of health information about you. The purpose is to give permission to leave certain health information on your voice or text messaging service. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____
(Please print)

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____
(Name of practice)

to call or text the following telephone numbers:

Mobile: _____

Home: _____

Work: _____

and leave detailed voice or text messages with the following information:

☐ Details about my next appointment (provider name, date/time, and callback number).

☐ Test and other exam results.

☐ Account payments, balances, or cost estimates.

☐ Only the following types of health information (including any dates):

_____

_____

☐ I **DECLINE**. Please do NOT leave any voice or text messages.

PURPOSE

Purpose of requested use or disclosure: ☐ Patient request *OR* ☐ Other

_____

_____

EXPIRATION

This authorization expires: _____
(Insert date)

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[1]

If the health information is being disclosed or used, I may inspect or obtain a copy of this health information.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: _____
(Name and address of practice)

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.[2]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Patient or Legal Representative Signature/Date/Time

Print Patient's or Legal Representative's Name

Legal Representative's Relationship to Patient

Witness Signature/Date/Time

Print Witness's Name

1. If any of the HIPAA recognized exceptions to this statement apply, this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment, or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

2. Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.