**COMMUNICATION AUTHORIZATION and ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE & ATLANTIC INTERNAL MEDICINE & PEDIATRICS POLICIES**

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Patient’s Printed Name Date of Birth

I authorize Atlantic Internal Medicine & Pediatrics to leave messages on my voice mail / answering machine regarding:

(Please check as appropriate)

\_\_\_ Care \_\_\_ Appointment Reminders

Please indicate the number you would like us to use for leaving messages:

Primary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In order to provide quality care, please provide the name(s) of individuals we can speak with or provide information regarding your care (i.e. spouse, family member, friend):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If I prefer not to communicate by phone, please choose an alternative below:

\_\_\_ Mail \_\_\_ Our Patient Portal

I acknowledge that if messages are left, my personal health information may be re-disclosed to other individuals or organizations and may no longer be protected by federal or state confidentiality laws.

Any questions I had regarding this authorization have been answered. This authorization is considered valid until I revoke it in writing. I may refuse to sign this authorization and this refusal will not affect my ability to obtain treatment.

Also, I have been presented with a copy of the Notice of Patient Privacy Practices, detailing how my health information may be used and disclosed as permitted under Federal and State law, and outlining my rights regarding my health information. I have also received a list of Atlantic Internal Medicine & Pediatrics policies.

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Signature of patient or authorized representative Date