AUTHORIZATION TO LEAVE PATIENT MESSAGES

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The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care. This includes communicating with patients at their homes, whether through the mail, by phone, or in some other manner. In addition, the Rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individual's privacy, covered entities should take care to limit the amount of information disclosed on the answering machine. For example, a covered entity might want to consider leaving only its name and number and other information necessary to confirm an appointment or ask the individual to call back.

A covered entity also may leave a message with a family member or other person who answers the phone when the patient is not home. The Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present; however, professional judgment should be exercised.

The HIPAA Privacy Rule also prohibits the practice from using or disclosing patient protected health information (PHI) outside the Notice of Privacy Practice without the authorization of the patient. Messages that contain patient PHI require the patient to sign an authorization form to receive messages by phone, fax, e-mail, voice mail, or any other means by which someone other than the patient might reasonably have access to the message, thereby potentially violating the patient's privacy rights under HIPAA. For example, messages that contain PHI would be test results, medication information, payment information, treatment plans, patient condition information, and anything else that is considered patient condition, treatment, or payment related.

You may elect to have your PHI provided to you by a message from the physician's office by signing this form in the space provided below. Once you have signed the form, future communication with you concerning your PHI may be provided to the designated relative or friend, sent by e-mail, fax or left on your voice mail at the number you provide to this office.

I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, for me with either of the two individuals listed below or by e-mail or voice mail at the numbers noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information.

Patient Name _____ **Date** _____

Phone Number _____ **E-mail Address** _____

Relative / Friend 1) Name _____ Phone _____

Relative / Friend 2) Name _____ Phone _____

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