



Authorization to leave patient message

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 cover entities from leaving a message 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, the 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 answer the phone when a patient is not home. The Privacy Rule permits covered entities to disclose limit information to family members, friends, or another person 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 a message by phone, fax, email, voicemail, 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 under HIPPA. For example, the message that contains PHI would be test results, medication information, payment information, treatment plans, patients condition information and anything else that is considered patient condition, treatment, or payment related.

You may elect to have PHI provide to you by a message from the physician's office by signing this form in the space provide to the designated relative or friend, sent by e-mail, fax or let on your voicemail at the number you provide to this office.

I understand my HIPPA rights and I request that this office leaves messages, including those PHIs, for me with either of the two individuals listed below or by email or voicemail at the numbers noted below. I understand that it is a responsibility to keep the practice informed of any changes to this information.

Patient Name _____ Date _____

Phone number _____ E-mail address _____

Detail Message ☐ Yes ☐ No

Relative/Friend 1) Name _____ Phone _____

Detail Message ☐ Yes ☐ No

Relative/Friend 2) Name _____ Phone _____

Detail Message ☐ Yes ☐ No