Beach Cities Orthopedics & Sports Medicine

Communication Authorization Form

The HIPAA privacy rule gives individuals the right to request Protected Health Information (PHI) in a confidential communication. I wish to be contacted in the following manner (check all that applies):

- ☐ **Home Telephone:** _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ **Cell Phone:** _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ **Work Telephone:** _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ **Written Communication:** _____
  - ☐ Okay to mail to my home address
  - ☐ Okay to mail to my work/office address
  - ☐ Okay to fax to _____
- ☐ **E-mail:** _____
- ☐ **Other:** _____

I hereby consent to the release of Protected Health Information (PHI) to the following individuals. I understand this authorization will be in effect until which time it is revoked.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

	03-23-2016
Patient Signature	Date
TEST, TEST	03-23-2016
Print Name	Date