PATIENT NAME_____ DATE_____

In compliance with HIPAA regulations to ensure patient privacy please complete the following form.

A. Please provide at least one of the following phone numbers to which we may call. Please also indicate if we may leave details by checkin the appropriate column. Please select ONLY ONE.

1. HOME TELEPHONE # _____

   [ ] Leave message with confirmation of appointment, or call back only.
   [ ] Leave message with results, detailed information, and appointment confirmation.

2. MOBILE TELEPHONE # _____

   [ ] Leave message with confirmation of appointment, or call back only.
   [ ] Leave message with results, detailed information, and appointment confirmation.

3. WORK TELEPHONE # _____

   [ ] Leave message with confirmation of appointment, or call back only.
   [ ] Leave message with results, detailed information, and appointment confirmation.

B. I am giving Monmouth Ocean Pulmonary Medicine permission to speak to the following people regarding my condition and treatment.

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

I hereby authorize Monmouth Ocean Pulmonary Medicine to furnish and / or fax protected health information to covered entities (healthcare providers, Hospitals, Health plan carriers)

SIGNATURE _____ DATE_____