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):

Ш	HC	ome Telephone:		_
		Okay to leave message with detailed inform	nation	
		Leave message with call back number only	,	
	Ce	ell Phone:		
		Okay to leave message with detailed inform		
		Leave message with call back number only	,	
	W	ork Telephone:		_
		Okay to leave message with detailed inform	nation	
		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-I	mail:		_
	Ot	ther:		_
ind		by consent to the release of Protected He duals. I understand this authorization will	• •	•
		·		
Patient Signature			Date	
Print Name			 Date	