AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hearby authorize Drs. Bohm and staff to contact me with test results and other protected health information in the following manner:

(Please check appropriate selections)

Home telephone # _____ answering machine:

☐ Do not call this number

☐ OK to leave message to call back only

☐ OK to leave message with results and detailed information

Cell phone# _____ voicemail:

☐ Do not call this number

☐ OK to leave message to call back only

☐ OK to leave message with results and detailed information

Work telephone#_____ voicemail:

☐ Do not call this number

☐ OK to leave message to call back only

☐ OK to leave message with results and detailed information

Other persons authorized to receive my health information:

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____Phone_____

Restrictions to above if any: _____

PLEASE COMPLETE THE FOLLOWING!

The above authorization will apply to the time period as follows:

From today until (☐) I cancel this authorization

OR (☐) until this date /___/

Patient name (print) _____Date of Birth /___/

Signature _____ Date _____