

Patient Information Authorization

I, _____ authorize the methods of communication of my protected health information as indicated below. I understand that under the HIPAA guidelines my patient information is kept confidential unless I provide written authorization.

The following person(s) can inquire regarding a medical service or billing statement, pick-up records, prescriptions and take messages pertaining to my health information.

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

4. _____ Relationship _____

I authorize Surgical Consultants of DuPage to leave a message regarding my test results, physician messages, insurance/billing information or appointment information. **Please initial each line that you authorize.**

_____ Telephone answering machine

_____ With a person listed above

Signature of Patient or Legal Guardian

Date