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PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED INFORMATION TO BE USEDAND/OR DISCLOSE (OPTIONAL)

Name or specifically identify these persons and/or entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment, and other healthcare operations.

Name of Authorized Person or Entity　　Relationship　　Phone#

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AUTHORIZATION FOR USE OF USPS MAIL, ANSWERING MACHINE, EMAIL AND/OR VOICEMAIL

DRS MINTZ & ABBOTT LLC dentists and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages or communication devices provided by our patients. Due to the new federally mandated HIPPA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, mobile phone and current home address on file would include but is not limited to prescriptions/pharmacy information, test or lab results, patient plans, future orders, appointment instructions for visits and procedures, and clinical information.

___ (Initial) I agree to allow DRS MINTZ & ABBOTT LLC dentists and healthcare staff to leave messages that include Protected Healthcare Information of the following: Please initial next to the applicable communication devices:

_____home phone number _______work phone number ______mobile number _____USPS Mail ______email

_____(Initial) No, I do not agree to allow DRS MINTZ & ABBOTT LLC dentists and healthcare staff to leave messages that include Protected Healthcare Information on my home, work, and cell phone.

____________________________　　　　____________________

Patient's Signature　　　　DATE