

Drs. Mintz & Abbott, LLC

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

Name or specifically identify a person 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 Number |
|-------------------------------------|--------------|--------------|
|                                     |              |              |

| Name of Authorized Person or Entity | Relationship | Phone Number |
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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 on 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, treatment 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 may include Protected Healthcare Information. 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 may include Protected Healthcare Information on my home, work, and cell phone.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
DATE