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COMMUNICATION AUTHORIZATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Black & Kletz Allergy will not release confidential health information, either in person or by telephone, email, or fax to any unauthorized individuals. When contacting the patient or guardian, we will not leave confidential health information on an answering machine or voicemail unless we are authorized in writing to do so. This information will also not be given to any unauthorized person who may answer your telephone (either at home or work).

I hereby consent to allow Black & Kletz, MD, PC. to reach me or leave confidential medical information for me via: (check all that apply)

☐ Home phone: (_____) _____-_____

☐ Cell phone: (_____) _____-_____

☐ Work phone: (_____) _____-_____

Email: _____@_____

I authorize Black & Kletz, MD, PC. to give confidential medical information to my: (list names)

☐ Spouse _____Phone _____

☐ Parents _____Phone _____

☐ Son/Daughter _____Phone _____

☐ Brother/Sister _____Phone _____

☐ Other _____ Phone _____

I acknowledge that this authorization can only be amended or rescinded by my written authorization.

_____ _____
Signature Patient/Parent/Guardian Date

_____ _____
Patient Name (Please Print) Account #