HARTWIG HEALTH

CONSENT TO LEAVE MESSAGES /SHARE INFORMATION WITH FAMILY & FRIENDS

I understand that my healthcare information is protected. I understand that, in order for us to leave detailed messages containing specific medical information on my voice mail or answering machine, I need to give permission for us to do so.

Consent for Leaving Messages

O **I prefer NOT to have voice mail messages from the clinic**

I give my permission for messages to be left on my phone number(s) below:

O Cell # _____ O Home #_____ O Work #_____

Regarding the following:

O Appointment O Account Payments O Test Results O Treatment

Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are family members or friends to whom I grant permission for Dr. Kim Hartwig and her representatives at our clinic to verbally discuss my care using their best judgment and grant them permission to disclose medical information that is relevant to my care or relevant for payment.

	NAME	RELATIONSHIP	PHONE NUMBER
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Regarding the following:

O Appointment O Account Payments O Test Results O Treatment

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

_____ _____ _____

Printed Name (Patient/Parent) Signature (Patient/Parent) Date