Authorization to Communicate and Leave Telephone Messages

Great Lakes Bay Surgery and Endoscopy Center

Great Lakes Bay Surgery and Endoscopy Center is committed to safeguarding your protected health information. To communicate verbally with another individual of your choosing, or to receive a telephone message regarding any upcoming procedures at the facility, pre-procedural questions regarding your clinical history, post-operative wellness check, or other important messages we are asking for your written permission. Please mark the appropriate boxes below.

☐ I authorize Great Lakes Bay Surgery Center to ***discuss*** with: _____

_____who is my _____, and is involved in my care, and any relevant information about my care and treatment. I understand that this may include confidential personal health information.

☐ I authorize Great Lakes Bay Surgery Center to leave telephone messages at my ***HOME*** or on my answering machine or voicemail. I understand that the message may include confidential personal health information.

Phone Number: _____

☐ I authorize Great Lakes Bay Surgery Center to leave telephone messages on my ***WORK*** answering machine or voicemail. I understand that the telephone message may include confidential personal health information.

Phone Number: _____

☐ I authorize Great Lakes Bay Surgery Center to leave telephone messages on my ***CELL*** answering machine or voicemail. I understand that the telephone messages may include confidential personal health information.

Phone Number: _____

☐ I do not authorize Great Lakes Bay Surgery to discuss any confidential personal health information with anyone other than myself; any relevant information regarding my care and treatment shall be provided only to me.

* None of the above allow access to printed copies or electronic access to your protected health information *

I hereby grant the above elected methods of communication about my protected health information. Furthermore, I understand that I may at any time change or rescind my election either by completing a new form, or by written correspondence with this facility; otherwise, this election is valid for 12 months.

Patient Name (print)	DOB
Patient/Parent/Legal Guardian Signature	Effective Date/Time
Patient/Parent/Legal Guardian Signature	Effective Date/Time

PATIENT STICKER