Voice Mail Authorization

I recognize that timely delivery of results of tests or other communication of health care information is important to the delivery of quality health care. I understand that there may be times when it is more efficient and/or effective to receive information telephonically. In order to allow for the free-flow of such information, the following acknowledgement is executed.

My signature below acknowledges that it is permissible for the member of Jefferson Community Physicians to communicate medical information to me by calling me at the following number: _____. If I do not answer and either a voice mail system or answering machine is initiated, Jefferson Community Physicians is authorized to leave information related to my medical condition on that voice mail system or answering machine. I recognize that this may mean that others who may be in the vicinity of the system or machine or who have access to the voice mail may intercept or hear the audio transmission of my private healthcare information. However, the risk of any such incidental disclose is so small and/or I do not have such privacy concerns in my household, that the benefits of efficient delivery of my healthcare information significantly outweigh any risk involved.

This authorization does not apply to the release of any information related to psychotherapy, HIV, or drug and alcohol testing, which are subject to more specific protections afforded by state law.

I recognize that I have the right to revoke this authorization at any time by calling Jefferson Community Physicians. Also, this authorization only allows for such communication that is related to past, present, or on-going treatment of me. Any authorizations required by the privacy rule issued as a result of the Health Insurance Portability Act or 1996 (“HIPAA”) that are for the release of information to someone other than myself will require a separate authorization form and is not incorporated into this document.

I acknowledge and understand the above:

_____ _____

Signature of Patient/Legal Guardian/Legal Representative Date