GOLDMAN
VEIN INSTITUTE

3535 Military Trail
Suite 204
Jupiter, FL 33458

2515 State Road 7
Suite 210
Wellington, FL 33414

AUTHORIZATION FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION

PATIENT NAME *(Print)* _____ _____
(First) (Last)

DATE OF BIRTH _____ **CHART #** _____

It is frequently necessary for personnel at this practice to communicate lab results, instructions, information about treatment, payment and other items of protected health information with our patients. It is frequently not possible to speak personally with the patient to leave this information. In the event that our personnel are not able to speak with you (the patient) directly, Please give us instructions about communicating it to you.

1. Messages may be left on my home answering device at _____
2. My home answering device does not identify me by name, but it is appropriate to leave messages for me there
   ❑ Yes ❑ No
3. Messages may be left for me on my Cell voicemail at _____
4. Messages may be left for me on my Work phone Voicemail at _____
5. Messages may be communicated to me via email at _____
6. Messages may be left for me with my partner (name) _____
7. Other Person(s) authorized to receive messages on my behalf:

   Name _____ at _____

   Name _____ at _____

I hereby release, Discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time.

Signature of Patient/ Guardian _____ Date _____

Relationship to patient if Minor _____