

TOTAL PATIENT CARE, LLC

HIPAA AUTHORIZATION

Patient Phone/Voice Mail Consent Form

Name: _____ Date of Birth: _____

Address: _____

I hereby give my consent for Total Patient Care, LLC (the "Practice") to communicate with me by the communication method listed below unless I "opt out" now or in the future.

Consent for Telephone Communication: I authorize Total Patient Care, LLC (the "Practice") to contact me at the telephone number(s) I have provided, including mobile numbers, and to leave voicemail messages or messages with an individual who answers the call. Such communications may include appointment reminders, lab or procedure results, follow-up care instructions, medication-related information, billing matters, and other information containing protected health information (PHI) related to my treatment or services.

I understand that telephone and voicemail communications are not secure methods of communication and may be accessed, intercepted, or disclosed to unauthorized individuals. The Practice cannot guarantee the confidentiality of such communications. I may revoke this authorization at any time by providing written notice to the Practice; however, such revocation will not apply to communications already made in reliance on this authorization.

Numbers for calls/voice messages: Home: _____ Cell: _____

In addition to the above, the Practice may communicate/release my health information with/to the following persons:

Names of person(s) that messages may be left with concerning any treatment:

Name: _____ Addr: _____ Tel: _____ Rel: _____

Name: _____ Addr: _____ Tel: _____ Rel: _____

Signed: _____ Date: _____

Patients have the right to revoke this authorization at any time. **Revocation must be submitted in writing** to the Practice and will apply prospectively, except to the extent the Practice has already relied on this authorization. Patients are responsible for notifying the Practice of any changes to their telephone numbers or contact information to ensure accurate and authorized communication.