HOUSTON PAIN SPECIALISTS

HIPAA DISCLOSURE:
PATIENT CONTACT & VERBAL RELEASE OF INFO CONSENTS

Patient Name (*print*): _____ DOB: _____

A) RELEASE OF PATIENT INFORMATION CONSENT

Consent to Verbally Release

I hereby give consent to release my personal health information either verbally or in writing to my family, friends, or others for purposes of obtaining treatment and/or for payment of medical services.

In that regard, Northwest Anesthesiology and Pain Services, PA and Houston Pain Specialists, have my permission to release my confidential personal health information to the following family members, friends, or other individuals who are involved in my care:

Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____

I understand that I have the right to revoke this authorization, at any time by providing written notice to this office. The revocation will take place on the date of the written notice and cannot be applied to prior disclosures.

A) AUTHORIZATION TO COMMUNICATE/LEAVE MESSAGES

From time to time it may be necessary for representatives of Northwest Anesthesiology and Pain Services, PA to leave messages for patients on their home or cellular phone. The purpose of these messages may be to return patient calls, remind patients that they have an appointment, to notify patients that the medical staff would like to discuss lab or procedure results, or to ask a patient to call one of the clinics of Northwest Anesthesiology and Pain Services, PA regarding an issue or concern. At no time will a representative of Northwest Anesthesiology and Pain Services, PA discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with your household members, your answering machine and/or on your voicemail. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Initial: _____ Consent to leave message with HOUSEHOLD MEMBERS (at phone numbers you have provided in record)

Initial: _____ Consent to leave message on HOME ANSWERING MACHINE (to phone numbers you have provided in record)

Initial: _____ Consent to leave message on VOICEMAIL and/or TEXT MESSAGING/SMS (to phone numbers you have provided in record)

_____ _____

Patient Signature Date

Northwest Anesthesiology and Pain Services, PA

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