PATIENT COMMUNICATION AUTHORIZATION

Patient Name: ____**Date of Birth:** ______/______/_________

I hereby authorize Moss and Maiocco MD LLC to communicate the protected health information (PHI) indicated below to me via (check all that apply, please write clearly):

☐ Home # (_________) __________-_____________ ☐ Mobile # (_________) __________-_____________

☐ Work # (_________) __________-_____________

☐ Email ____

☐ You may leave messages **(if yes, check all that apply)** ☐ Voicemail Message ☐ At home ☐ Mobile ☐ At Work

Information to be disclosed (check all that apply):

____All health care information (no restrictions)
____Lab/Test results (no restrictions)
____Medication /Rx information
____ Appointment reminders
____Critical results only
____Other ___________________________________

Please complete this section ONLY if you allow someone other than yourself (e.g. spouse) to have access to your Personal Health Information.

I hereby authorize Moss and Maiocco MD LLC to grant the following individual access to the information specified below.

Name (please print): ____

Telephone # if different from the patient (_________) __________-_____________ Relationship to Patient: ________________________

Information permitted to be disclosed (check all that apply):

____All health care information (no restrictions)
____Lab/Test results (no restrictions)
____Medication /Rx information
____ Appointment reminders
____Critical results only
____Other ___________________________________

____ _________ ________/_________/_____________
Patient Signature (or Legal Guardian) **Date**

Patient Consent for Use of Email Communication
(Complete this section ONLY if you wish to receive email communication)

To better serve our patients, this office may send certain routine lab tests and biopsy results to your email address If you choose to receive communication electronically. **At the present time we are not receiving email messages regarding medical questions or appointment scheduling**. Any questions or appoin needs that you have must all be transacted through telephone **(203) 374-5546** or regular US mail. **Urgent or immediate attention needs are not appropriate v email.**

This office is dedicated to keeping your medical record information confidential. We use the most current encryption software available when communicating electronically. However, despite our best efforts and due to the nature of email, third parties may have access to messages on your end. (e.g. – if you are using a email – some companies monitor your communications as they consider email corporate property)

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I understand that this office will not be responsible for information loss, delay, or breaches in confidentiality that are due to factors beyond this office's control.
I understand that communication relating to diagnosis and treatment will be filed in my medical record.
By signing below, you are agreeing to the above email policy and that we may send medical related correspondence to you via email.

____ _______/_______/____________
Patient Signature (or Legal Guardian) **Date**
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