Geriatric and Medical Specialists of Michigan, PLC

HIPAA Authorization Form

Patient Name: _____

This is an acknowledgement that I have been offered a copy of the HIPAA disclosure form.

_____ _____

Signature of Patient Date

Please list the names of the person(s), if any, whom we may discuss you medical condition/care with.

_____ _____

Name Phone

_____ _____

Name Phone

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home:

_____

Please indicate if you would like all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL" YES_____ NO_____

Please print the telephone number where you would like to receive calls about your appointments, test results, or other health care related information if other than your home phone number: _____

Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? YES_____ NO_____

**Any test results will not be left in the form of a message regardless if they are "normal" or "abnormal".

Patients Signature_____Date_____