SURGICAL SPECIALISTS OF COLORADO, P.C.

Phone Message Consent
Confidential Communication Authorizations

The Health Insurance Portability and Accountability Act (HIPPA) gives you the right to request the method and location for which we communicate confidential information to you. In order to protect the privacy and confidentiality of your information, please complete the following to indicate your preferences for contact and disclosure of confidential information.

By signing below, you authorize the staff of Surgical Specialists of Colorado to call and leave a detailed message on your voicemail, answering machine or with your designated person. Without your signed consent, the staff may only leave their name and phone number as the message for you to return the call. You have the right to revoke this authorization at any time. Revocation of this authorization must be done in writing. Unless otherwise revoked, this authorization is valid permanently.

Please Select ONE Option Below

A: I DO CONSENT TO LEAVE DETAILED MESSAGES:

I, _____, DOB: _____, give Surgical Specialists of Colorado permission to leave detailed phone messages regarding my medical care at the following (check all that apply):

- Patient Home Telephone: _____
  (Home Phone Number)
- Patient Cellular Phone: _____
  (Cell Phone Number)
- Patient Work Telephone: _____
  (Work Phone Number)

And/or detailed information may be disclosed to the following designated individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

_____ _____
(Patient Signature or Signature of Legal Representation) (Date)

B: I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I, _____, DOB: _____, wish to be contacted personally and I do not authorize detailed phone messages regarding my medical care to be left on my phone.

_____ _____

(Patient Signature or Signature of Legal Representation) (Date)