DESERT BLOOM FAMILY PRACTICE

CONSENT TO LEAVE DETAILED MESSAGE

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Name_____ DOB _____

I authorize the associates of Desert Bloom Family Practice to leave detailed messages (as I have marked below) on any or all phone numbers I have listed below.

_____
_____
_____

☐ Desert Bloom Family Practice can leave NORMAL results on the phone number(s) listed above.

☐ Desert Bloom Family Practice can leave detailed messages regarding ANY results on the phone number(s) listed above.

☐ Desert Bloom Family Practice can leave detailed messages regarding my medical care on the phone number(s) listed above.

☐ Desert Bloom Family Practice may ONLY leave call back information on the phone number(s) listed above, with **NO** details.

I understand that it is my responsibility to contact Desert Bloom Family Practice regarding any changes to the phone numbers I have listed above.

Signature_____Date_____

Witness_____ Date_____