MACK
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AUTHORIZATION TO DISCLOSE PRIVATE HEALTHCARE INFORMATION

HIPAA ALTERNATIVE ACCESS FORM

Patient: _____ DOB: _____

Messages:

I authorize the office of Leo W. Mack, Jr., M.D., P.A. to call my home (or other number that I provide) prior to my scheduled appointment, and review instructions that may or may not include private healthcare information. Such review of instructions may be left on an answering machine, voice mail, or with someone at my residence.

Preferred method of contact:

- ☐ Phone #: _____
- ☐ Text #: _____
- ☐ Email: _____
- ☐ I **DO NOT** AUTHORIZE any messages.

Release of Information

I authorize the release of confidential communication of protected health information to be given to the following person(s):

- ☐ **No one** other than myself
- ☐ Spouse: _____ Phone #: _____
- ☐ Child: _____ Phone #: _____
- ☐ Child: _____ Phone #: _____
- ☐ Other: _____ Phone #: _____

  Relationship to patient: _____

Patient Signature: _____
(or authorized person / relationship)

Witness (employee): _____

Date: _____