

Irwin Endelman M.D

Patient's Name:

Date of Birth:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Under HIPPA requirements, we are not allowed to discuss your health information with anyone without your consent. Please sign below if you authorize Irwin Endelman M.D to discuss information regarding your appointment, lab results, procedures or billing with another person. Please write below all individuals to whom your protected health information (medical or financial) may be disclosed.

1. Relationship to patient:
2. Relationship to patient:
3. Relationship to patient:

Patient Signature:

Date:

AUTHORIZATION TO LEAVE A MESSAGE ON ANSWERING MACHINE/VOICEMAIL

Under HIPPA requirements, we are not allowed to discuss your health information with anyone without your consent. Please sign below if you authorize Irwin Endelman M.D to leave information regarding your appointment, lab results and procedures on an answering machine or voicemail.

AUTHORIZATION TO SEND AN EMAIL MESSAGE

Under HIPPA requirements, we are not allowed to discuss your health information with anyone without your consent. Please sign below if you authorize Irwin Endelman M.D to send an email regarding your appointment, lab results and procedures to the following email address:

Email Address:

Patient Signature:

Date: