Date:	
Patient Name:	Date of Birth:

MESSAGE AUTHORIZATION

If we need to contact your, may we leave a message at your:

Home Telephone Number Yes ____ No____ (　　) ____________________

Cell Phone Number Yes ____ No____ (　　) ____________________

Employer Phone Number Yes ____ No____ (　　) ____________________

REQUEST FOR SPECIAL PERMISSION

I understand that my physician may use or disclose my protected health information (PHI) for the purpose of treatment, payment and health care operations. My physician may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend.

I hereby permit HAHC to disclose this information to the following people:

Persons Name	**Relationship to Patient**

Comments or special instructions

____ ____________

Signature of patient or his/her authorized representative Date