

HIPAA /Appointment Contact Information

How would you like to be contacted by Zipper Urogynecology Associates about your upcoming appointments?

Please E-mail me at: _____

Please Text me at: _____ if you choose the text option you will receive one acceptance message that allows us to send continue to text this number.

Please leave me a voice message at: _____

Please list person(s) authorized to receive my medical information, billing information, test results, appointment information, etc.

<u>Name</u>	<u>Relationship</u>	<u>Phone Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Zipper Urogynecology Associates may notify me with test results, billing information, and other information regarding my health information as follows:

_____ Message on answering machine (phone number) _____

_____ Message on work voice mail (phone number) _____

_____ Message on cell phone (phone number) _____

_____ Email address _____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Patient Name

Signature

DOB: _____

Date: _____

This authorization is **not** valid for the request of printed copies of your medical records. You and only you or your legal representative must sign a release of records form to obtain copies of your medical records.

