

AUTHORIZATION FOR HEALTH CARE AND
APPOINTMENT REMINDERS AND PERMISSION TO SAY
YOUR NAME

Park Primary & Urgent Care and staff members of the practice may need to use your name, address and phone number to contact you with appointment reminders and health related information to your interest.

- ❖ We will call you by name when it is time for your appointment.
- ❖ We may call your name out loud to receive information while you are in the waiting room.
- ❖ We may leave a message on your answering machine in the case of your absence. Such information may be subject to re-disclosure and may no longer be protected by privacy policies.

By signing this form you are giving us authorization to say your name and to contact you with reminders and information.

You may restrict the individuals or organizations to whom your health information is released or you may revoke your authorization at any time. The request for revocation will have to be given to us in writing. Any information released prior to receiving the request for revocation cannot be contested.

In addition if you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse authorization, your refusal will not affect the treatment we provide or the methods used to obtain reimbursement for your care.

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- I _____ have carefully read the above and hereby do authorize **Park Primary & Urgent Care** to say my name and disclose health information in the manner described above.
 - I _____ have carefully read the above and hereby do not authorize **Park Primary & Urgent Care** to say my name and disclose health information in the manner described above.

Signature

Date