IN-SYNC AND SOCIAL

Consent to Communicate Health Care Information

Patient Name:

Due to In-Sync & Social's specialty type of practice, there may be times when it is necessary to leave personal, insurance, appointment, and therapy related information with someone other than a child's parent/guardian, or on an answering machine. Under the new HIPAA guidelines, we are no longer permitted to leave such messages, without your prior approval.

Please review each of the following, signing your initials at each space you approve, and then sign the bottom of this form.

_____ I authorize the staff of In-Sync & Social to leave messages regarding insurance/billing matters with anyone who answers my home phone.

_____ I authorize the staff of In-Sync&Social to leave messagesregarding insurance/billing matters on my home or cell phone voicemail.

_____ I authorize the staff of In-Sync&Social to leave messagesregarding insurance/billing matters at my place of employment, using the telephone number provided by me.

_____ I authorize the staff of In-Sync&Social to leave messagesregarding appointments with anyone who answers my home phone.

_____ I authorize the staff of In-Sync&Social to leave messagesregarding appointments on my home or cell phone voicemail.

_____ I authorize the staff of In-Sync&Social to leave messagesregarding appointments at my place of employment, using the telephone number provided by me.

_____ I authorize the staff of In-Sync&Social to leave messages regardingtherapy matters with anyone who answers my home phone.

_____ I authorize the staff of In-Sync&Social to leave messages regardingtherapy matters on my home or cell phone voicemail.

_____ I authorize the staff of In-Sync&Social to leave messages regardingtherapy matters at my place of employment, using the telephone number provided by me.

Parent/Guardian Name:_____ Relationship:_____

Parent/Guardian Signature:_____ Date:_____