Broomfield
Family Practice
Family Medicine/Obstetrics
Pediatrics

1420 W Midway Blvd
Broomfield, CO 80020
303.466.1866 Phone
303.466.4081 Fax

Phone Message Consent
Confidential Communication Authorization

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request the method and location for which we communicate confidential information to you. In order to protect the privacy and confidentiality of your information, please complete the following to indicate your preferences for contact and disclosure of confidential information.

By signing below, you authorize the staff of Broomfield Family Practice to call and leave a detailed message on your voicemail, answering machine or with your designated person. Without your signed consent, the staff may only leave their name and phone number as the message for you to return the call. You have the right to revoke this authorization at any time. Revocation of this authorization must be done in writing. Unless otherwise revoked, this authorization is valid permanently.

A: I DO CONSENT TO LEAVE DETAILED MESSAGE:

I, _____, DOB: _____, give Broomfield Family Practice permission to leave detailed phones messages regarding my medical care at the following (check all that apply):

- o Patient Home Telephone: _____ (Home Phone Number)
- o Patient Cellular Telephone: _____ (Cell Phone Number)
- o Patient Work Telephone: _____ (Work Phone Number)

And/or detailed information may be disclosed to the following designated individual(s):
Name: _____ Relationship: _____
Name: _____ Relationship: _____

_____ _____
(Patient Signature or Signature of Legal Representative) (Date)

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B: I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I, _____ DOB: _____, wish to be contacted personally and I do not authorize detailed messages regarding my medical care to be left by phone.

_____ _____

(Patient Signature Or Signature of Legal Representation) (Date)