DelVal Integrative Health Partners, LLC
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HIPPA Permission for Medical Information Release

Patient Name	Date
Personal Representative Name	Relationship to Patient

It is our office policy that we will not release confidential and/or unauthorized information by home or cell phone, work phone, voicemail or answering machine unless instructed by you to do so. When we call to speak with you or return your phone call, we will only leave a message if the name and telephone number is provided on the recorded message to identify the residence and you have authorized us to leave a message. We will not leave information with any unauthorized person who may answer the telephone.

By signing this form, I hereby give this medical office and its staff permission to leave medical information pertaining to my care in the manner(s) set forth below. I assume responsibility to notify this office of any changes in this information and shall not hold the office liable for failure to do so.

Please answer the following questions.

	Yes	No
Can we leave a message on your answering machine or voicemail?		
Can we leave a message with a household member?		
Can we give medical information to a household member?		

Name of household member(s) authorized to receive your medical information	Relationship

Signature of Patient /Guardian	Date