



Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. MGM Medical Associates, Ltd. will not ask why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____, give my permission for MGM Medical Associates, Ltd.
(Print Name of Patient)

physicians and employees to communicate information related to my personal health, as indicated below. This request supercedes any prior request for communication of information I may have made.

Phone

You May May Not contact me regarding my appointments by telephone.

You May May Not contact me regarding my test results by telephone.

You May May Not contact me regarding my condition and treatment by telephone.

You may use the following telephone numbers:

Work _____ Home _____ Cell Phone _____

You may You may not leave messages on my answering machine/voice mail.

You may leave messages with the following people (Print Names):

Mail

Send mail regarding appointments, my test results or my condition and treatment to the following address: _____

Signature: _____ Date: _____ MRN: _____
(Parent or Legal Guardian if Patient is a Minor)

Name: _____ Relationship: _____