ALAN NILI D.O.

FAMILY PRACTICE

Diplomate of American Board of Family Practice

Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996 you have the right to request that communications concerning your personal health information be made through confidential channels. Dr. Nili's office 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 to Dr. Nili's office to communicate
(Print Name of Patient)
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 ☐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:

____

____

E-Mail Address

____

Signature: ____ Date:______________________
(Parent or Legal Guardian if Patient is a Minor)

Name: ____ Relationship: ______________________