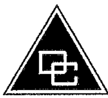

DELTA CONSULTANTS
OF SOUTH COUNTY, INC.

AUTHORIZATION TO COMMUNICATE

Appointment and Account Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we have authorization to communicate with anyone other than our immediate client(s) or the person legally responsible for them (parent/guardian).

In the course of our work with you and your family, it is sometimes necessary for our office staff to contact you regarding an appointment or the status of your account. Our office staff may occasionally need to telephone you to schedule, change or confirm an appointment. Your signature will reflect your approval that our office staff may do this. Our office staff is aware of HIPAA regulations and has been trained in privacy.

I authorize Delta Consultants of South County, Inc. to communicate with members of my immediate family or household regarding my appointments.

Please tell us how you would like us to contact you and if we may leave messages:

- *Home phone:* ________________________________ ___ *Yes* ___ *No*
- *Work phone:* ________________________________ ___ *Yes* ___ *No*
- *Cell phone:* ________________________________ ___ *Yes* ___ *No*
- *Email:* ________________________________ ___ *Yes* ___ *No*
- *Text:* ________________________________ ___ *Yes* ___ *No*

Please tell us if there is anyone in your family or household who you want to exclude from this authorization.

I understand that I may withdraw this authorization at any time by written notice.

Client or Parent/Guardian (Print Name): ____

Client or Parent/Date (Signature): ___________________________________ Date:__________

I give permission to release billing information to *EZClaim Inc.* for the purpose of record keeping and billing of client or insurance companies. I also give permission to *EZClaim Inc.* to communicate with me regarding problems with my account.

Client or Parent/Guardian (Print Name): ____

Client or Parent/Guardian (Signature): ___________________________________ Date:__________

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