DRS. GIRGIS & ASSOCIATES
Breathe Better, Hear Better, Sleep Better

Communication Authorization Form

The following methods of communication of my protected health information as indicated below have been authorized. I understand that this consent is valid until it is revoked by me.

Under the requirements of HIPAA, we are not allowed to release information without the patient or guardian's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to anyone you must indicate that on this form. You are under no obligation to provide an individual with access to your medical information.

The practice may discuss my medical care and billing, authorize the pickup of records and prescriptions, and leave messages pertaining to my health information with the following person(s):

1_____Relationship _____ Phone:_____

2_____Relationship _____ Phone:_____

_____ NONE

I authorize Drs. Girgis & Associates to leave a voicemail and send information regarding my personal health history, such as test results, physician messages, insurance or billing information or appointment information to the patient portal. Please select yes/no below.

_____ YES

_____ NO

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient's Name Patient's Date of Birth

_____
Print Name of Legal Guardian (if applicable)

If you are not the patient, please specify your name and relation to the patient.

MRN:_____
(Internal Office Use Only)

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908 N. Elm Street, Suite 306
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5201 S. Willow Springs Rd., Suite 240 LaGrange, IL 60525

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