Corina Going, ND, PLLC

Naturopathic Physician and Classical Homeopath

HIPAA Communication Request

Patient Name_____ Date of Birth: _____

I authorize this office to contact me in the following manner: (check all applicable)

[ ] Telephone number: ( )_____ [ ] Home [ ] Cell

[ ] O.K. to leave a detailed message

[ ] O.K. to leave a message with call back name and number only

[ ] DO NOT CONTACT ME. I will call in for any information I need.

[ ] Other: _____

[ ] I authorize the release of my account billing information to:_____

Relationship to patient: _____

[ ] I authorize the release of my appointment information to:_____

Relationship to patient: _____

This office **CAN NOT** release your account balance or your appointment date or time to anyone but you unless they are listed on this form. I understand that I have the right to request changes to this communication form. **Any changes must be made in writing and a new form completed.** This form remains in effect unless written notice is given by me.

_____ _____

[ ] Patient Signature [ ] Guardian Signature Date