HIPAA Disclosure Information

(Heath information may include, but is not limited to: Appointment reminders, Medication Education, Lab Results, Diagnostic Results, Treatment Plan or Options)

Patient Name:_____DOB:_____

*If yes, do you give permission to send electronic communication through the portal? YES NO

Best Phone Number to use:_____ Home Work Cell (Circle)

Is it okay to leave a detailed message on this number? YES NO

I hereby authorize Geoffrey E. Baum, D.O., Orthopedic Surgeon to release or discuss information related to my health status to the selected below: (example: Spouse, Children, Family Member, etc…)

☐ I DECLINE (If you check "decline" we only have permission to speak with you)

_____ _____

Name & Relationship to Patient Patient's Initials

_____ _____

Name & Relationship to Patient Patient's Initials

_____ _____

Signature of Patient or Legal Representative Date

This form is valid until such time as the patient updates information with our office