Mount Sinai

Name

Date of birth

MRN

AGREEMENT TO RECEIVE MESSAGES CONTAINING PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize

Doctor's name or his/her designee

to leave a message containing PHI necessary for my care as follows (SELECT ONE):

◯ On my voicemail at home AND with authorized contact.

◯ **ONLY** on my voicemail at home: _____

◯ **ONLY** on my mobile voicemail: _____

Signature

Personal Representative to sign only if patient is a minor or unable to sign on his/her own behalf.

Print name

Signature of patient or authorized representative

Name of authorized representative

Relationship to patient

Date