



Mount
Sinai
Doctors

Agreement to Receive Messages Containing Protected Health Information (PHI)

Name: _____

MRN: _____

- I **DO NOT** authorize Dr. _____ or his/her designee to leave a message containing PHI necessary for my care.

I hereby authorize (CHECK ONE):

- All Mount Sinai Doctors providers or their designees
- Dr. _____ or his/her designee

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

- On my answering machine at home **AND** with anyone who answers my phone.
- ONLY** on my answering machine at home.
- ONLY** at the following telephone number: (_____) _____

Signature Patient: _____ Date: _____

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

Signature Personal Representative: _____

PRINT NAME: _____ DATE: _____

AUTHORITY/RELATION TO PATIENT: _____