NARCISA A. DUSA, MD
INTERNAL MEDICINE
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Communication Consent Form

Dr. Dusa and her staff are often in a position where they need to speak with persons other than you, the patient regarding your appointment and healthcare. Please read the statement below and check yes or no to give your consent.

I consent to having messages regarding my appointments, as necessary:

Left on my home voice mail	___ Yes ___ No
Left on my office voice mail	___ Yes ___ No
Left with another person at my home number	___ Yes ___ No
Emailed to my **secure** e-mail address on file	___ Yes ___ No
Discussed directly with me over the phone	___ Yes ___ No

I give my consent to **Dr. Dusa** and her staff to discuss my Protected Health Information (PHI), as may be necessary, with the following people listed below. My signing of this form does not authorize the release or a written PHI. I understand that I must sign a separate authorization form for the release of written PHI as stated in the *HIPAA Notice and Authorization of Privacy Practices*.

Please be specific in the information below:

Spouse: _____ Phone: _ _ _ / _ _ _ / _ _ _ _

Friend: _____ Phone: _ _ _ / _ _ _ / _ _ _ _

Child: _____ Phone: _ _ _ / _ _ _ / _ _ _ _

Other: _____ Phone: _ _ _ / _ _ _ / _ _ _ _

_____ _ _ / _ _ / _ _ _ _
Printed Name Signature Date