Restore Occupational Therapy
693 Main Street
New Milford, PA 18834
570-465-2027

Authorization to Share Information

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

Patient name: ______________________________ DOB: ________________

Leave appointment and billing messages on/with:		**Leave medical information messages on/with:**	
On home phone:	____yes ____no	On home phone:	____yes ____no
On cell phone:	____yes ____no	On cell phone:	____yes ____no
Mobile text:	____yes ____no	Mobile text:	____yes ____no
On office voicemail:	____yes ____no	On office voicemail:	____yes ____no
w/another person:	____yes ____no	w/another person:	____yes ____no
Send via mail:	____yes ____no	Send via mail:	____yes ____no
Send via email:	____yes ____no	Send via email:	____yes ____no

If you answered yes to allowing us to discuss your appointment, billing and/or medical information with another person, please list their name (s), relationship(s) and phone# below:

Name: **Relationship:** **Phone:** **Cell phone:**

____

____

Additional HIPPA contact instructions: ____

____

Patient or legal representative signature: ___________________________________
If legal representative indicate relationship: ____________________
Date: ______________________

This authorization will expire one year from the date of signing, unless otherwise notified.