



7 Yorkshire Street  
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### Designated Individuals' Authorization- HIPAA Compliance

To protect your patient confidentiality, we need to know if there is a phone number (with voicemail) for you where we can leave the results of your laboratory test or other sensitive information. Please indicate the information below, and we will keep this in your file until you instruct Us in writing to remove it.

I give Dogwood Family Medicine employees permission to leave confidential Healthcare information for me at the following phone number(s):

*If none please note:*

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*I understand these numbers will be used until I notify Dogwood Family Medicine in writing if they are no longer to be used.*

I authorize the following people to receive information regarding my medical status including access to my medical records and financial records ongoing.

Name	Relationship	Phone

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Signature:** \_\_\_\_\_