IRMC
PHYSICIAN GROUP
THE COMMUNITY'S CHOICE

Telephone Protocol

TELEPHONE MESSAGES

It is our policy that we and/or our affiliates contact patients regarding appointments, scheduling, billing and/or payments, questions on your account, results of tests, etc. In addition, unforeseeable emergencies do sometimes arise when it may be necessary for the physician or staff to contact you. It is our office policy to leave a message at your home or on your cell phone (even if you are charged for the call under your phone plan) if you are not available, or we may need to contact you at work if an emergency arises.

(please circle)

May we contact you at home? Yes ☐ No ☐
May we contact you at work? Yes ☐ No ☐
May we contact you on your cellular phone? Yes ☐ No ☐
(even if you are charged for the call under your phone plan)
May we leave a message on your answering machine? Yes ☐ No ☐
May we leave a message at your workplace? Yes ☐ No ☐
May we leave a message on your cellular phone voicemail? Yes ☐ No ☐

If you answer "no" to all the questions above please state how we may contact you.
_____

This office adheres to strict policies with regard to release of confidential information. I understand your policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating my care.

AUTHORIZED REPRESENTATIVE

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Password: _____

I understand I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular diagnosis/disease. Any such limitations must be described below in writing. I understand by leaving this section blank, I am creating no limitations of disclosure.
_____

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand my medication history may be obtained utilizing electronic information exchange and this protected health information may provide valuable information for my healthcare provider. I hereby authorize IPG to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

_____ _____
Patient Name Date of Birth

_____ _____
Patient/Responsible Party Signature Date