# TELEPHONE CONTACT AUTHORIZATION

The Purpose of the *Telephone Contact Authorization* is to allow us to speak with people that you trust about your medical condition.

Understand that family members or other people can call us and discuss their feelings about your treatment, but we are not allowed to discuss your medical treatment or condition if we are not authorized to speak with them. This can sometimes be frustrating for close friends and family members, but unless you specify who we are able to talk with, we are not allowed to speak about your medical condition.

This form allows us to talk to the appropriate people about your condition, and exclude those who should not have that information.

We recommend that you include at least one trusted person for us to contact in case there are concerns about you.

# TELEPHONE CONTACT AUTHORIZATION

**Robyn K. Sato, D.O.**
**150 Laguna Rd Suite A**
**Fullerton, CA 92835**
**Phone: 714-738-5525 & Fax: 714-738-1352**

Purpose: This document allows our medical practice permission to discuss your medical care with other health practitioners in compliance with HIPPA.

Patient Name: _____
Patient DOB: _____

I give my permission to the practitioners of this medical office to contact a physician, psychologist or therapist to discuss my medical condition by use of telephone, e-mail and/or fax. I understand that these are not considered completely secure means of communication under Federal law.

The practitioner(s) name is/are as follows:

_____

Name City Telephone

_____

Name City Telephone

_____I give my permission for practitioners of this office to speak about my condition with family members, or other significant persons, who are as follows:

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

I understand that I may revoke this permission by written letter at any time.

_____ _____

Patient Date Witness Date