Mount Sinai Doctors *Long Island Heart*

Agreement to Receive Messages Containing Protected Health Information (PHI)

Name: _____

MRN: _____

☐ **I DO NOT authorize Dr. _____ or his/her designee to leave a message containing PHI necessary for my care.**

I hereby authorize (CHECK ONE**):**

☐ All Mount Sinai Doctors providers or their designees

☐ Dr. _____ or his/her designee

to leave a message containing PHI necessary for my care as follows (CHECK ONE):

☐ On my answering machine at home **AND** with anyone who answers my phone.
☐ **ONLY** on my answering machine at home.
☐ **ONLY** at the following telephone number: (_____) _____

Signature Patient: _____ **Date**: _____

{Personal Representative to sign only if patient is a minor or unable to sign on his/her own behalf}

Signature Personal Representative: _____

PRINT NAME: _____ **DATE**: _____

AUTHORITY/RELATION TO PATIENT: _____

MR-225A (Rev 5/13)