

VINCENT F. SAYAN, M.D., LLC  
General and Laparoscopic Surgery

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**CONFIDENTIAL COMMUNICATIONS/DISCLOSURE OF PERSONAL HEALTH INFORMATION**

Patient Name: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Best time to reach you: \_\_\_\_\_

Patients under 18 yrs: Parent/Guardian: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

May we contact you at home? Yes/No (please circle)

May we contact you at work? Yes/No

May we leave a message? Yes/No

May we leave messages w/another party? Yes/No

Other than we and your insurer, with who else may we share information about your account? \_\_\_\_\_  
Relationship: \_\_\_\_\_

May we discuss your medical/billing records with your spouse or other family members? Yes/No  
If yes, with whom (ie: family member, secretary) \_\_\_\_\_

Any restrictions on messages left? \_\_\_\_\_

Whom do you authorize to pick up information from our office on your behalf, including but not limited to sealed envelopes, lab orders, prescriptions, etc: \_\_\_\_\_

By signing this agreement, I am consenting for this office or its representatives to the use and disclosure of my patient protected health information to carry out treatment, payment, or Healthcare operations. I may change above designee's at any time by filling out and signing a new form. I may revoke my consent in writing except to the extent this practice has already made disclosures upon my prior consent. I also understand that if I do not sign this consent, your office may decline to provide treatment to me or the patient listed above.

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date