

CARROLL ARTHRITIS, P.A.

412 Malcolm Drive, Suite 306
Westminster, MD 21157

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By signing below, I acknowledge that I was made aware of, by the office of Carroll Arthritis, P.A., the **NOTICE OF PRIVACY PRACTICES**, regarding protection of my personal health information.

Patient Name: _____

Date of Birth: _____

Signature of Patient or Legal Guardian: _____

Date: _____

Communication Authorization

Carroll Arthritis, P.A. providers and/or staff may contact me at home/work phone numbers or at my home address regarding my diagnosis, results, treatment and care, or payment. I may request other means of communication (such as cell phone or mail to a different address) or I may deny (in writing) particular means of communication.

YES, you may call my cell phone at _____. I understand that cell phones are NOT considered a private/secure method of communication.

NO, please do not contact me by the following means: _____

I understand that I may authorize Carroll Arthritis, P.A. providers and/or staff to share medical/billing information about my care to relatives, caretakers, etc. and I shall list them below:

Communication authorization shall be expired under any of the circumstances as listed below:

- 1. Upon written request for records release for reason of transfer of care.
- 2. Upon written request by patient or legal Power of Attorney.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____