



INFORMATION DISCLOSURE

According to HIPPA regulations, we must obtain permission to leave medical information on voice mails, answering machines or with persons other than you.

Please fill out and sign below.

I give permission for the staff of Dolphin Medical Group to leave messages on the following:

- Leave a message on my home phone answering machine or voice mail.
- Leave a message on my work voice mail.
- Leave a message on my cell phone voice mail.
- Leave a message with the following people: (please include name and phone number) _____

- Fax information to the following number: _____

Date: _____ Signature: _____