**Dr. Rosario B. Gonzaga**
**957 National Highway, LaVale, MD 21502**
**Phone (301) 729-9475 Fax (301) 876-4438**

## Authorization for Release of Protected Health Information

Patient Name: _____ Patient Date of Birth: _____

Signature of Patient: _____ Date of Signature: _____

### Request for Confidential Communication of your Protected Health Information

Representative's Relationship to Patient:

Specific Request:

Printed Name of Patient Representative: Representative's Date of Birth:

Signature of Representative: Date of Signature

| Signature: | Date: | Initial: |
|---|---|---|

Please write the e-mail for which you would like to receive communications_____

### Please Circle the Following

| | | | |
|---|---|---|---|
| May we leave messages concerning your appointments with whomever answers your calls? | Yes | No | N/A |
| May we leave messages on a voice mail? | Yes | No | N/A |
| May we discuss your appointment/treatment with your spouse/significant other? | Yes | No | N/A |
| If you are over the age of 18 and still living at home, may we discuss your appointment/treatment with your parent(s)? | Yes | No | N/A |
| If you are over the age of 18, may we discuss your appointment and/or treatment with your children? | Yes | No | N/A |
| May we e-mail messages to you on the e-mail you provide? | Yes | No | N/A |
| May we text you on the number provided? | Yes | No | N/A |
| May we take your picture for identify and documentation purposes only? | Yes | No | N/A |

Please list family/friends for whom you have deemed we can disclose your Protected Health Information:

| | |
|---|---|
| Name: | Relationship: |
| Name: | Relationship: |