Roomika T. Baig, M.D., LLC

Acknowledgement of Receipt of Privacy Notice

Communication Authorization

Doctor Baig 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 any other means of communication (cell phone, different mailing address) or I may deny a particular means of communication in writing (below).

☐ *I may be contacted on my cell phone at _____. I understand cell phones are NOT considered a private/secure method of communication.*

☐ *I may not be contacted by the following means: _____ .*

I understand that I may authorize Doctor Baig to share medical/billing information about my care or my child's care to relatives, caretakers, close friends, etc.

Name	*Relationship*	*Phone Number*
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

1) Upon written request for records release for reason of transfer or care.

2) Upon written request by patient or legally responsible person.

3) In case of a minor having reached the age of maturity.

*Patient:*_____ *Home Phone:*_____

*Guardian Signature:*_____ *Date:*_____