# CONSENT TO RELEASE HEALTH INFORMATION

By signing this form, I grant permission to David J. Cox, M.D. to allow the following individuals listed below to have access to all medical information contained in my health record as well as my accounting information. I understand that this consent will remain in effect unless revoked by me in writing.

| INDIVIDUAL'S NAME | RELATIONSHIP |
|---|---|
| | |
| | |

**Patient Name:** _____ **Date of Birth:** _____
(PRINT NAME)

**Signature:**_____ **Date:** _____

# E-BILLING AUTHORIZATION

By signing this form, I grant permission to USMEDX (billing department for David J. Cox, M.D.) to send my statement in the form of an e-mail.

☐ Yes, Please send my account statement to my e-mail address
☐ NO, Please continue to send my account statement through the postal service.

**Patient Name:** _____ **E-Mail** _____
(PRINT NAME)

**Signature:**_____ **Date:** _____

# RELEASE OF PROTECTED HEALTHCARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICEMAIL

I give my consent and authorization for the medical and billing staff of David J. Cox, M.D. to leave protected healthcare information (PHI) about me on my answering machine or voicemail via telephone at the number(s) listed below. I understand that I may revoke this permission at any time by submitting my request in writing to this office. If I choose not to authorize release via the telephone, I understand that I am responsible for calling the office to retrieve results of all tests and procedures.

**Phone Number:** _____ **HOME**
_____ **WORK**
_____ **CELL**
_____ **OTHER**

**Release of PHI via telephone authorized:** _____
SIGNATURE

**Release of PHI via telephone NOT authorized:** _____
SIGNATURE