PRIVACY POLICY

RONALD S. KAHN, M.D.

Board Certified Family Physician

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AUTHORIZATION FOR TELEPHONE CONTACT FOR DISCUSSING ANY MEDICAL OR PERSONAL INFORMATION

Due to the number of patients who have voice mail and/or answering machines, we need information about how to communicate with you.

IF WE CANNOT REACH YOU, MAY WE LEAVE A MESSAGE REGARDING TEST RESULTS, APPOINTMENTS, SCHEDULING AND/OR BILLING MATTERS ON YOUR ANSWERING MACHINE OR VOICEMAIL?

YES **NO**

IF YOU ARE NOT AVAILABLE, OR IN CASE OF AN EMERGENCY, MAY WE LEAVE THE ABOVE INFORMATION WITH A RELATIVE OR OTHER PERSON?

YES **NO**

If YES, please state the name and relationship below:

NAME:_____ **RELATIONSHIP:**_____ **PHONE:**_____

NAME:_____ **RELATIONSHIP:**_____ **PHONE:**_____

I request that payment for authorized insurance benefits be made to Ronald S. Kahn, M.D. for any service furnished me by that physician. I authorize release to my insurance carrier and its agents any medical information about me needed to determine these benefits payable for related services.

X_____ **TODAY'S DATE:**_____

Patient Signature