ADDITIONAL INFORMATION REGARDING DISCLOSURE
OF PATIENT MEDICAL INFORMATION

Marlene J. Mash, MD & the Associates, honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Sending Authorizations to Marlene J. Mash, MD: If mailing an authorization, please mail to our address:

Marlene J. Mash, MD & Associates
545 West Germantown Pike, Suite 100
Plymouth Meeting, PA 19462

Verbal Communication Only. This authorization allows for verbal communication (both in person and on the telephone between Marlene J. Mash, MD & Associates and the designated person(s) on this form. It does not allow for copies of medical records to be released.

Voice Mail Messages. Marlene J. Mash, MD & Associates Providers and their staff recognize confidentiality as a very important part of your relationship with them. To protect your confidentiality, they will not routinely leave messages on your personal messaging system (voice mail or answering machine or with your spouse, family members or any other individual) unless you specifically give your permission to do so. This authorization may be used to share this information in the manner that you specify.

Patient Portal. Your email that you provide is for the specific use of Marlene J. Mash, MD & the Associates, providers and staff, for the sole purpose of communicating with you regarding your health. This information will not be shared. The Portal is a secured website that uses SSL when logging in to maintain security. If you would like additional information regarding the security features of the Portal, please ask a staff member for more information.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so for either all or part of it. Except as permitted under applicable law, Marlene J. Mash, MD & the Associates, Providers may not refuse to provide you treatment or other healthcare services if you refuse to sign.

Revocation. You have the right to revoke this authorization, in writing at any time. However, your written revocation will ***not*** affect any disclosures of your medical information that the person(s) listed on the release form have already made, in reliance on this authorization, before the time that you revoke it.

Confidential Voice Mail:
Please ***check below*** where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) blank if you ***do not wish*** to receive voice mails.

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

Information for Health Patient Portal:
Please ***write below*** an email address that we can send you a invite to participate in our patient portal. The portal allows you the ability to communicate with Marlene J. Mash, MD in regards to: appointment requests, medication refill requests, and allows bidirectional communication between you and your provider and allows them to personally inform you regarding labs and other test results.

Email Address:

Check here if you would like to be included in our NEWSLETTER SUBSCRIPTION. You will be able to opt out at any time. ☐

Your signature ***below*** confirms your approval of these updated HIPPA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____
DATE SIGNED _____

Marlene J. Mash, MD & Associates
545 West Germantown Pike
Suite 100
Plymouth Meeting, PA 19462
www.DrMarleneMash.com
484-351-8268

Authorization for Verbal Communication and/or to Leave Voice Mail Messages Regarding My Personal Health Information and Permission to Invite Me to participate in our Patient Health Portal.

This does not authorize release of copies of medical records without a signed Authorization to Release Medical Records by patient or guardian

Patient Information

Name- Last, First, MI	Date of Birth:

Information to be disclosed: verbal communication only regarding patient's care-no copies of medical records provided

Please Provide your current telephone numbers

Home Phone	Cell Phone
Work Phone	Other Phone

We normally contact our patients between 8 a.m. and 5 p.m. Monday through Friday. Please ***check below*** where you would prefer to be contacted during these hours.

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____ If When we need to reach you after hours, or to confirm an appointment after hours, please ***check below*** where you prefer to be called:

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

Your Protected Health Information Designees:

If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information).

This person (designee) will also be able to call the office on your behalf.

Please print the name and relationship to you/patient of each designee below:

Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:

Check here if you ***do not want*** your health care information discussed with anyone other than yourself. ☐