Tel: (401) 421-1924 • Fax: (401) 454-6828

HIPAA Compliant Patient Message Authorization

I, ________________________________ hereby authorize Rhode Island Medical Imaging Vein Institute to leave phone messages for me to confirm appointments, or routine business at phone number ____________________ &/or ____________________ as it relates to my medical care at Rhode Island Medical Imaging Vein Institute.

I also give permission for Rhode Island Medical Imaging Vein Institute to discuss my Personal Health with my...

Spouse ____

Son ____

Daughter ____

Other ____

____Date:__________
Signature

____Date:__________
Witness