



Notification Policy

Name: _____

It is our policy to release confidential and/or unauthorized information to a home telephone answering machine, work telephone, voicemail, cellphone, and/or pager. When returning calls and answering machine picks up, we do not leave a message unless it is an appointment reminder. Information also will not be left with an unauthorized person who may answer the phone.

If you would like to have information released to someone other than yourself, please complete the following:

I authorize the staff of South Shore Neurologic Associates, PC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

- Yes No Home Telephone _____
 Yes No Home Answering Machine _____
 Yes No Work Telephone/Voicemail _____
 Yes No Cellphone and Voicemail _____

Please list the names of authorized people we may leave messages with: (i.e. spouse, boyfriend, girlfriend, parent, grandparent, etc.)

- | | | |
|------------|--------------------|--|
| Name _____ | Relationship _____ | _____ Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Name _____ | Relationship _____ | _____ Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Name _____ | Relationship _____ | _____ Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Name _____ | Relationship _____ | _____ Yes <input type="checkbox"/> No <input type="checkbox"/> |

Who may we discuss your financial situation with?

- | | | |
|------------|--------------------|--|
| Name _____ | Relationship _____ | _____ Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Name _____ | Relationship _____ | _____ Yes <input type="checkbox"/> No <input type="checkbox"/> |

Signature _____

Date _____

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 DAVID BESSER, MD
 SAMSON MEBRAHTU, MD
 NORMAN PFLASTER, MD
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