Patient Name: ____ Date of Birth: _________________

MY PREFERRED CONTACTS

The HIPAA Privacy Rule gives individuals the right to direct how their healthcare provider communicates with them.

Please check all that apply:

☐ You have permission to leave information on my home answering service regarding my medical care and test results.

☐ You have permission to leave information on my mobile phone regarding my medical care and test results.

☐ You have permission to send information via email regarding my medical care and test results. I understand and acknowledge that e-mail communication is not secure. E-mail can be intercepted during transmission; and unencrypted messages (and any attachments) can be read, and potentially copied and forwarded, by anyone. Unencrypted emails can also be easily viewed by someone other than the recipient if, for example, I access messages via a smart phone or tablet.

☐ You have permission to send information via text (SMS) on my mobile phone regarding my medical care and test results.

Please list name(s) of spouses, child(ren) and others involved in care as applicable:

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. You may use this form to name specific individuals who you want us to share your information with; this may include information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up, and scheduling appointments. Please update this information in writing promptly if your preferences change. Please indicate the person(s) you prefer we share your information with below. (If no one, please write “none”)

• Name: ____ Telephone: _____________________

Relationship: _________________ Email: ____

• Name: ____ Telephone: _____________________

Relationship: _________________ Email: ____

• Name: ____ Telephone: _____________________

Relationship: _________________ Email: ____

Important Note: We may share your information as set forth in our Notice of Privacy Practices to other persons not named on this form as needed for your care or treatment or the payment of services we have provided

Patient Signature: ____ Date: ________________

To be signed by patient’s parent or legal guardian if patient is a minor or otherwise not competent