HIPAA CONTACT DISCLOSURE FORM

Due to HIPAA regulations we will need a clear understanding of how we may contact you and whom we may discuss your information with:

Your Full name: _____

- May we contact you by cell phone? (circle one) Yes No
- Work Phone? (circle one) Yes No
- May we leave a voice mail on your phone? (circle one) Yes No
- May we contact you by email? (circle one) Yes No

This contact is for confirming appointments, informing of office closures, following up with missed appointments, answering questions after hours or ANY OTHER necessary office follow up.

- If "yes" please provide your current cell phone number: _____
- If "yes" please provide your current work phone number: _____
- If "yes" please provide your preferred email address: _____
- Do we have permission to send text information or contact this same number? (circle one) Yes No

NOTICE: IT IS THE RESPONSIBILTY OF YOU, THE PATEINT, TO INFORM US IMMEDIATELY OF ANY CHANGES TO THIS PERMISSION OR CHANGES OF NUMBERS THAT COUD CAUSE RELESE OF YOUR PERSONAL INFORMATION TO ANYONE OTHER THAN YOURSELF OR THOSE TO WHOM YOU GIVE PERMISSION.

_____ (Initial) The care provider is permitted to share ***any and all*** medical information with the following individuals listed below, including test results, sensitive information as stipulated by State law, and information disclosed during office visits.

_____ (Initial) The care provider is permitted to share **some** medical information with the individuals listed below, including test results, sensitive information as stipulated by state law, and information disclosed during office visits. Except: (state clearly what MAY NOT be shared)

_____

Persons authorized to receive my medical information: (Include: Full name, relationship, and phone number.)

NAME: RELATIONSHIP: PHONE NUMBER:

_____

_____

_____

_____

_____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Printed name: _____ Signature:_____

DOB:_____ Date:_____

This authorization is not valid for the request of printed copies of your medical records. You and only you (or your legal personal representative) must sign a Health Information Release form to obtain copies of your medical records.

Effective 10/01/2017