HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

____ Patient Reviewed HIPAA Privacy Statement (Previous Page)

PLEASE CIRCLE YOUR SELECTIONS

Can detailed APPOINTMENT messages be left…

On a Home Phone?	Yes	No
On a Mobile Phone?	Yes	No
Via Mobile Text?	Yes	No
On a Work Phone?	Yes	No
With Another Person?	Yes	No
Via E-Mail/Portal?	Yes	No

Can detailed MEDICAL messages be left…

On a Home Phone?	Yes	No
On a Mobile Phone?	Yes	No
Via Mobile Text?	Yes	No
On a Work Phone?	Yes	No
With Another Person?	Yes	No
Via E-Mail/Portal?	Yes	No

Special HIPAA Contact Instructions (if applicable): ________________________________

____

Emergency Contact: Name________________________ Phone# (____) _______-_________

Relationship: _________________ Address: ____________________________________

Can appointment/medical information be released to this person? **Yes** **No**

Under the privacy act known as "HIPAA", I authorize Davenshire Medical Center to release information regarding my health care, health records and/or test results to the person(s) listed below.

Name_________________________________ Relationship________________________

Name_________________________________ Relationship________________________

Name_________________________________ Relationship________________________

Name_________________________________ Relationship________________________

PATIENT'S NAME *(please print)*: ____

DOB: ______________________

____ ______________________

Signature of Patient or Responsible Party Date

This information is for use by your physician as part of your confidential medical records.
R06272017