

PATIENT INFORMATION

The following methods of communication are appropriate. I understand that under the HIPAA guidelines my patient information is held confidential unless authorized by my signature.

The following are designated as primary contacts regarding my health care. If other members who are not listed below act on my behalf, I understand that authorization by me needs to be obtained in writing.

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____
5. _____ Relationship: _____

In an effort to provide you with timely information regarding your health care, we are asking that you complete the following:

Phone calls to patient regarding test results and medical information are made throughout the day and in the evenings as well. Please supply us with a number(s) of where you would like to be reached during this time.

1. _____ Home Work Cell
2. _____ Home Work Cell
3. _____ Home Work Cell

If you are not available at the time we try to call you, may we leave medical information on an answering machine or voice mail?

_____ Yes _____ No

(If your answering machine does not identify your last name or phone number we will not leave medical information.)

It is the responsibility of the patient to contact us with any changes to the above information in writing.

Patient Signature: _____ Date: _____

Medical Record Number: _____
(Office Use Only)