HIPAA COMMUNICATION AUTHORIZATION

Patient Name: _____
Date of Birth: _____
Authorized Family/Contacts
I authorize the following person(s) to receive information about my care:
Name: _____ **Relationship:** _____
Phone: _____
Name: _____ **Relationship:** _____
Phone: _____
Phone & Voicemail Permission
Phone Number(s) Office May Use:
1.
2.
3.
Please select one:
☐**YES** — I authorize the office to leave confidential messages on voicemail at the numbers listed above.
☐ **LIMITED** — The office may leave only:
Appointment information Call-back request Other: _____ ☐ ☐ ☐
☐ **NO** — Please do not leave voicemail messages containing health information.
Family/Representative Communication
I authorize the office to speak with the individuals listed above regarding:
Appointments Medical/Treatment Information Test/Lab Results ☐ ☐ ☐
Medications Billing/Insurance ☐ ☐ ☐**All of the above**
I understand that I may revoke or change this authorization in writing.
Patient Signature: _____
Date: _____
Representative Name (if applicable): _____
Relationship/Authority: _____

Patient Acknowledgement of Healthcare Information Privacy

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may cause this organization at any time at the address of record to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this acknowledgement in writing at any time, except to the extent that you have taken action relying on this acknowledgement.