Patient Information:

Last Name: **First Name:** **MI:**

SSN: **DOB:** **Account:**

Address:

City, State, Zip: **Phone:**

Email Address:

Patient Privacy Directive

In our efforts to comply with the Health Insurance Portability and Accountability Act(HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

·Please provide us with a phone number(s) that we or an automated service may leave messages regarding appointments:

______________________________ ______________________________

·Please provide us with the name(s) and phone number(s) that we may talk to regarding your appointments:

______________________________ ______________________________

·Please provide us with the name(s) and phone number(s) that we may talk to regarding your treatment and test results:

______________________________ ______________________________

·Please provide us with the name(s) and phone number(s) that we may talk to regarding your billing:

______________________________ ______________________________

·Please provide an email that we may communicate health information to you with:

____

·Please provide a cell phone number that we may text health information to you with:

____

You must inform us **in writing** of any changes in your directives.
I acknowledge that all of the above is accurate.

______________________________ ______________________________

Signature ***Printed Name*** ***Date***

I acknowledge I have seen or been offered a copy of the "Notice of Privacy Practices"

______________________________ ______________________________

Signature ***Printed Name*** ***Date***

______________________________ ______________________________

Relationship if Patient Representative *Physician Office Representative*