Privacy Notice Acknowledgement and Communication Consent

Patient Name: ____ Date of Birth: ____________________

Name and Phone number of your family physician (PCP)

____ (______) _____________________

Please list below the pharmacy you use, including cross streets or address and phone number:

____

____

We must call you at times to give you what is classified as protected health information. Please let us know how we can contact you with this information and if we can leave a message.

Can we leave a detailed or confidential messages on your home phone?

Yes ______ No ______ Home number: ____

Can we leave detailed or confidential messages on your cell phone?

Yes ______ No ______ Cell phone number: ____

Can we mail test results to your home? Yes ______ No ______

Exclusions/Alerts (Please note any information that you do not want released to authorized individuals):

____

____

We must call you at times to give you what is classified as protected information. Can we speak to anyone other than you regarding lab results, radiology results or other issues regarding your health?

Name Relationship

1)____

2)____

Must Sign Below for all information given:

My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Arizona Rheumatology Consultants, PLC Notice of Privacy Practices.

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Patient Signature Date