Patient Privacy Directive

Patient Last Name: _____ First Name: _____

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), 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 the phone number(s) that we or an automated service may leave messages regarding appointments:

_____ _____

Please provide us with the phone number(s) that we or an automated service may leave messages regarding treatments and/or medication information:

_____ _____

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/your child's treatments and/or medications.

_____ _____

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

_____ _____

_____ _____

Please provide an email address that we may use to communicate protected health information.
(Employee email is subject to the conditions set forth by the employer and may not be private.)

Email: _____ Confirm Email: _____

Please provide us with the name and number of your emergency contact:

_____ _____

You must inform us in writing of any changes in your directives. I acknowledge that everything 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*