In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- Home or Cell Phone: _____
  - OK to leave a message with detailed information
  - Leave name and doctor with call back number only
- Work Telephone: _____
  - OK to leave message with detailed information
  - Leave name & doctor with call back number only
- When unable to contact me by phone, a written communication may be sent to my home address.
- Other: _____

l consent and authorize the release of NORMAL test results to the following:

- Only Myself
- Telephone Answering Machine/Voice Mail
- My spouse: _____
- My children: _____
- My parents: _____
- Other: _____

I consent and authorize the release of ABNORMAL test results to the following:

- Only Myself
- Telephone Answering Machine/Voice Mail
- My spouse: _____
- My children: _____
- My parents: _____
- Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

- Yes
- No

I consent and authorize your office to contact me via text and by automated telephone calls regarding medical, insurance and billing related matters

- Yes
- No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- Yes
- No

ADVANCED DIRECTIVE

Do you have an advanced directive (Living Will)?

- Yes
- No

Patient Signature (Must be 18 or older to sign) Date

Print Name Date of Birth