



## PATIENT CONFIDENTIAL COMMUNICATION

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PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information; please complete the following, which tells us how you wish to be contacted and who, we may discuss your healthcare with.

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

### HOME TELEPHONE

- Do not contact me at home
- Leave message with department/office name and call back number on voice mail/answering machine at home phone.
- Leave message with medical information on voice mail/answering machine at home phone.
- Give information to family member(s)

\_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship)

\_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship)

\_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship)

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

- Information regarding the patient's diagnosis and treatment of HIV/AIDS
- Psychotherapy notes from a Psychiatrist or Psychotherapist.
- Treatment for alcohol or drug abuse reports

### WORK TELEPHONE

- Do not contact me at work
- Leave message with department/office name and call back number on voice mail/answering machine at work phone.

Our office will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form. By signing below, you agree to be communicated in the above manner

\_\_\_\_\_  
Signature of Patient/Personal Representative

\_\_\_\_\_  
Date