HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

PLEASE CIRCLE YOUR SELECTIONS

Can detailed APPOINTMENT messages be left…		
On a Home Phone?	Yes	No
On a Mobile Phone?	Yes	No
Via Mobile Text?	Yes	No
On a Work Phone?	Yes	No
Via E-Mail/Portal?	Yes	No

Can detailed MEDICAL messages be left…		
On a Home Phone?	Yes	No
On a Mobile Phone?	Yes	No
Via Mobile Text?	Yes	No
On a Work Phone?	Yes	No
Via E-Mail/Portal?	Yes	No

Special HIPAA Contact Instructions (if applicable): _____

_____

Emergency Contact: Name_____ Phone# (_____) _____-_____

Relationship: _____ Address: _____

Can appointment/medical information be released to this person? **Yes** **No**

Under the privacy act known as "HIPAA", I authorize Davenshire Medical Center to release information regarding my health care, health records and/or test results to the person(s) listed below.

FOR PEDIATRIC PATIENTS: PLEASE LIST ALL PARENT/GUARDIAN NAMES

1. **Name**_____

   Relationship_____ **Phone#** (_____) _____-_____

2. **Name**_____

   Relationship_____ **Phone#** (_____) _____-_____

3. **Name**_____

   Relationship_____ **Phone#** (_____) _____-_____

4. **Name**_____

   Relationship_____ **Phone#** (_____) _____-_____

PATIENT'S NAME *(please print)*: _____

DOB: _____/_____/_____

_____ ____ _____

Signature of Patient or Responsible Party **Date**