2026 HIPAA FORM

MEDICAL INFORMATION COMMUNICATION

PATIENT _____ **DOB** _____

As our patient, we may need to communicate with you when you are not in the office. To maintain your privacy, please indicate your contact preferences.

LIST PHONE NUMBER(S) YOU PREFER WE USE TO CONTACT YOU

Primary Phone Number (ENTER PHONE NUMBER)	CELL	HOME (CIRCLE ONE)
Secondary Phone Number (ENTER PHONE NUMBER))	CELL	HOME (CIRCLE ONE)
How do you want to receive the automated appointment reminder	(circle one) PHONE TEXT BOTH	
If we need to contact you directly, may we leave a voicemail message?	**YES**	**NO**
If you want to sign up for the patient portal please give your email address.		
NOTE If you currently have the portal, please note that messages from the office may be sent to you directly through this portal!**		

TELL US WITH WHOM WE MAY SPEAK

WITHOUT PERMISSION, we **WILL NOT** release any medical information to anyone other than you.

☐ **DO NOT** release medical information to anyone **other than myself**.

☐ I give permission to contact in an emergency or release medical information pertaining to me to the individuals below:

NAME	Relationship to Patient	Telephone Number

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences in the release of my medical information.

_____ _____

Signature of Patient or Patient's Legal Representative DATE