PATIENT COMMUNICATION PREFERENCES

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize PRACTICE NAME to contact you and how you wish to be contacted (check all that apply):

	ORDER OF PREFERENCE	OK TO LEAVE VOICEMAIL?	PHONE NUMBER
HOME PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
CELL PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
WORK PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
ALTERNATE PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
PATIENT PORTAL & SECURE EMAIL	☐1 ☐2 ☐3 ☐4 ☐5	**EMAIL ADDRESS:**	
☐None of the above			

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize PRACTICE NAME to disclose your PHI to the following individuals (check all that apply):

Name:________________________________**Relationship to Patient**:_____________________

Telephone:(   )_____________________**Email**:

Types of Information:☐Appointment Reminders☐Results (lab test, X-Ray, etc)☐Financial☐Other:

Okay to contact via:☐Telephone☐Leave a Voice Mail☐Patient Portal & Secure Email☐Other:

Name:________________________________**Relationship to Patient**:_____________________

Telephone:(   )_____________________**Email**:

Types of Information:☐Appointment Reminders☐Results (lab test, X-Ray, etc)☐Financial☐Other:

Okay to contact via:☐Telephone☐Leave a Voice Mail☐Patient Portal & Secure Email☐Other:

Name:________________________________**Relationship to Patient**:_____________________

Telephone:(   )_____________________**Email**:

Types of Information:☐ppointment Reminders☐Results (lab test, X-Ray, etc)☐inancial ☐ther:

Okay to contact via:☐elephone☐Leave a Voice Mail☐Patient Portal & Secure Email☐Other:

☐None of the above

Signature:______________________________________**Date**: ______________________

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information. amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information ; 3) your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

Name of Patient	Signature of Patient/Date Signed
Name of Patient's Personal Representative	Signature of Patient's Personal Representative/ Date Signed

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FOR INTERNAL USE ONLY

Name of Employee:_____ Signature of Employee: _____

If applicable, reason patient's written acknowledgment could not be obtained:

☐ Patient was unable to sign.

☐ Patient refused to sign.

Other:_____