<u>HIPAA</u>

Patient Information:

Name:___________________________ DOB:_________________

Street Address:____

City, State, Zip:____

Patient Privacy Directive

In our efforts to comply with the Health Insurance Portability and Accountability Act(HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please provide us with the name(s) and phone number(s) that we may speak to and/or leave messages regarding appointments, treatment, test results, and billing:

Name/Number/Relationship:____

Name/Number/Relationship:____

Please provide us with an email that we may communicate any of the above health information to:____

You must inform us **in writing** of any changes in your directives.
I acknowledge that all of the above is accurate.

_____________________________ ______________________
Signature ***Date***

_____________________________ ______________________
Printed Name ***Relationship***