HIPAA FORM FAMILY PRACTICE OF CENTRASTATE

In our continuing efforts to protect your privacy, please identify the person/persons with whom we may discuss your care:

NAME	TELEPHONE	RELATIONSHIP TO) PATIENT
I do not wisl	h to have my care discussed with	anyone other than myself.	
	Telephone Commu	nication with Patient	
	Please select preferred	mode of contact below	
PLEASE CHEC	K ONE OPTION BELOW:		
	Number:		
Ok to leave m	essage with detailed information	l	
Leave messag	e with callback numbers only		
OR	•		
PLEASE CHEC	K <u>ONE</u> OPTION BELOW:		
Cell Telephone N	umber:		
Ok to leave m	essage with detailed information	ı	
Leave Messag	ge with callback numbers only		
Please	select your preferred choice fo	r Confirmations of an appointme	nt
Sand a taxt ma	assas for reminder of ennointme	ent via Callabana	
	ssage for reminder of appointment	_	
Send an automo	ated call for reminder of appoint	ment via Home telephone	
PATIENT SIGNA	ATURE	DATE	
	r	DATE OF DIDTH	
PRINTED NAM		DATE OF BIRTH	
Updated 2/28/201	9		