



Site information/Label

Site: _____

Address: _____

HIPAA Contact Information

Patient Name: _____ Date of Birth: _____

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

You may contact me by mail at my address on record Yes No

You may contact me by phone at my contact number on record Yes No

You may leave a message on my contact number on record Yes No

You may contact me/leave a message at the following number: _____

You may discuss my healthcare needs/release necessary medical information with family and/or others involved in my care as listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient or Authorized Representative

Date

Relationship to Patient