BE HEALTHY TO THE CORE

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