Preferred Contacts

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home. We invite you to share with us your preferred place and manner of communication. You may update or change this information at any time; please do so in writing. I prefer to be contacted in the following manner (check all that apply)

Home Telephone: _______ **Yes** _______ **No**

OK to leave a message with detailed information: _______ **Yes** _______ **No**

Cell Phone: _______ **Yes** _______ **No**

OK to leave a message with detailed information: _______ **Yes** _______ **No**

Work Telephone: _______ **Yes** _______ **No**

OK to leave a message with detailed information: _______ **Yes** _______ **No**

Written Communication: _______ **Yes** _______ **No**

OK to leave a message with detailed information: _______ **Yes** _______ **No**

Email: _______ **Yes** _______ **No**

OK to leave a message with detailed information: _______ **Yes** _______ **No**

Please provide email address: ____

We respect your right to indicate who you prefer we involve in your treatment or payment decisions and/or who we share your Information with. including about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick up and scheduling appointments. Please note, however, that we share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided. Please update this information if your preference changes.

Please indicate the person(s) you prefer we share your information with below:

Name: ____________________	Name: ____________________	Name: ____________________
Telephone: ________________	Telephone: ________________	Telephone: ________________
Relationship: ______________	Relationship: ______________	Relationship: ______________

(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

____________________	____________________	____________________
Print Name	Signature	Date