MY PREFERRED CONTACTS

Patient Name: _____ Date of Birth: _____

Address:

_____

Street City / State / Zip

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. You have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below. Please update this information in writing promptly if your preferences change.

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal

1)Full Name:_____ Relationship:_____

_____ _____

Telephone:Email:

_____ _____

2) Full Name: Relationship: _____

_____ _____

_____ _____

3) Full Name: Relationship: _____

Telephone:_____ Email:

_____

_____ _____

_____ _____

Telephone:Email:

_____ _____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons not named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature: Date:

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