Doylestown Medical Associates

HIPAA CONTACT CONSENT FORM

We understand that medical information about you and your health is personal and we are committed to protecting it. In order to comply with the HIPAA (Health Insurance Portability and Accountability Act) privacy notice of 1996, we are requesting that you designate to whom we may disclose specifics of your health information (i.e. laboratory and radiology results and necessary follow-up appointments.)

Which is the primary number you want us to contact you at?

_____ ❑Home ❑Cell ❑Work

May we leave a message on your message at this number?

_____ Yes, call back number only

_____ Yes, may leave detailed message

_____ No

If you are not available, is there a family member with whom we are authorized to speak?

1. Name: _____ Relationship_____
   (Please print) (Please print)

2. Name: _____ Relationship_____
   (Please print) (Please print)

3. Name: _____ Relationship_____
   (Please print) (Please print)

_____ I decline to give authorization to any person / (s) at this time

Patient Name: _____ Signature: _____
(Please print)

Date: _____