

HIPAA Form

ONE 2 WELLNESS

HIPAA FORM

In our efforts to comply with the health information privacy act, HIPAA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

PLEASE CHOOSE YOUR CHOICE RESPONSES TO THE FOLLOWING QUESTIONS.

May we leave messages concerning your appointments/treatment with a co-worker, receptionist or secretary that regularly answers your phone calls? (choose one)

YES

NO

If yes, please list specific names:

May we leave messages on an answering machine at home? (choose one)

YES

NO

May we leave information with a spouse or significant other? (choose one)

YES

NO

If yes, please list specific names:

Is there anyone that is not listed above that we can give information to? (choose one)

YES

NO

If so, please specify?

For any children above 18 that are still living at home, may we discuss your appointments/treatments with your parent(s) or Guardian? (choose one)

YES

NO

If yes, please list parent names:

I would like to receive regular e-mail updates and/or newsletters: (choose one)

YES

NO

E-mail address

You must inform us, in writing, of any changes in your directives. This record takes effect September 1, 2003 and will be kept in your file with your acknowledgment of receipt of our Notice of Privacy Practices.

Signature:

Date

Print Name
