Patients Protected Health Information Preferences

Please refer to the "HIPAA NOTICE OF PRIVACY PRACTICES" trifold provided for more information about your Protected Health Information.

Telephone Communication Preferences

Location	May we call you here?		Can we leave a message?	
• Home	□ Yes	□ No	□ Yes	□ No
• Work	□ Yes	□ No	□ Yes	□ No
• Mobile Phone	□ Yes	□ No	□ Yes	□ No
• Other	□ Yes	□ No	□ Yes	□ No

Mail Communication Preference

May we send mail to your home address? □ Yes □ No

If no, please provide an alternate mailing address below:

Address _____ City _____ State _____ Zip _____

Other Communication - Other than you, your insurance carrier, and health care providers involved in your care, who can we talk with about your health care information?

Check all that apply	Name	Phone Number			
□ Spouse	_____	_____	□ Home	□ Work	□ Cell
□ Child	_____	_____	□ Home	□ Work	□ Cell
□ Parent	_____	_____	□ Home	□ Work	□ Cell
□ Other	_____	_____	□ Home	□ Work	□ Cell

□ By checking this box, I do not wish to disclose any information with anyone

May we fax a copy of your medical records from today's visit to your physician to ensure continuity of care? □ Yes □ No

Physician _____ Office # _____ Fax # _____

Referring Physician _____ Office # _____ Fax # _____

- I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information
- I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information
- I acknowledge should I change my mind I have the right to revoke all active authorizations on file by completing a Revocation of Authorization to Release Protected Health Information

PATIENT / PERSONAL REPRESENTATIVE SIGNATURE _____ DATE _____ TIME _____

PRINTED NAME _____ RELATIONSHIP TO PATIENT _____

Dignity Health. St. Rose Dominican

Patient Sticker