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PATIENT CONTACT FOR PROTECTED HEALTH INFORMATION FORM (HIPAA)

DUE TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), WE ASK THAT PATIENTS PROVIDE A PHONE NUMBER WHERE WE CAN LEAVE DETAILED MESSAGES REGARDING TEST RESULTS AND OTHER PERSONAL INFORMATION.

IF YOU DO NOT HAVE A PHONE NUMBER WHERE WE MAY LEAVE A MESSAGE, PLEASE INDICATE "NO" ON THE LINE BELOW.

NOTE: THIS NUMBER MAY BE DIFFERENT THAN YOUR BILLING OR APPOINTMENT CONFIRMATION PHONE NUMBERS. IT IS YOUR RESPONSIBILITY TO UPDATE YOUR INFORMATION AS IT CHANGES.

_____YES, I AGREE TO LEAVE A PHONE NUMBER FOR DETAILED MESSAGES INCLUDING, BUT NOT LIMITED TO TEST RESULTS.

_____YES, I AGREE TO LEAVE AN EMAIL ADDRESS FOR THE POTENTIAL OF CONFIRMATIONS AND REMINDERS.

_____NO, THESE DO NOT APPLY TO ME.

EMAIL: _____

PHONE NUMBER: _____

PRINT NAME: _____

_____ _____

PATIENT SIGNATURE DATE