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PREFERRED AND PERMITTED CONTACTS

Patient Name:_____
Please Print Name

Home#_____
____Can leave detailed message
____ No messages permitted at this number

Work#_____
____Can leave detailed message
____No messages permitted at this number

Cell#_____
____Can leave text messages
____Can leave detailed message
____ No messages permitted at this number

____ I give permission to be contacted by email: _____
Email address

____ I give permission to share test results/other information with my spouse/parent/other.

____Speak only to me regarding any results/information.

____I give my permission to list my name only in newsletters/internet if I am a contest / promotion winner.

Persons allowed to speak with:

_____
Name/Relationship Phone#

_____
Name/Relationship Phone#

HIPAA Privacy Notice has been posted and made available for my review. I understand and agree to the rights contained in this notice.

I authorize this practice to disclose healthcare information for the purpose of treatment, payment, and healthcare operations as described in the privacy notice.

_____
Signature Date

Revised 02-2016