HIPPA FORM

KEEPING YOUR PERSONAL HEALTH INFORMATION PRIVATE

NAME ________________________________ Date of Birth ________________

ADDRESS ____

SOCIAL SECURITY NUMBER ____

HOME/DAYTIME CONTACT NUMBER ___________________________________

1) DO WE HAVE PERMISSION TO CALL YOUR HOME? ( ) YES ( ) NO

2) MAY WE LEAVE A MESSAGE WITH OTHER RESIDENT? ( ) YES ( ) NO

3) MAY WE LEAVE A MESSAGE AT YOUR HOME ON YOUR ANSWERING MACHINE OR VOICE MAIL? ( ) YES ( ) NO

4) TO WHOM AT YOUR RESIDENCE MAY WE TALK TO ABOUT YOUR MEDICAL TREATMENT:

NAME ______________________________ RELATIONSHIP _______________
HOME PHONE _____________ CELL ________________ OTHER ____________

5) IS THE ABOVE PERSON YOUR EMERGENCY CONTACT ( ) YES ( ) NO
IF NOT, PLEASE LIST YOUR EMERGENCY CONTACT BELOW:

NAME ______________________________ RELATIONSHIP ________________
HOME PHONE _____________ CELL _________________ OTHER ____________

6) DO WE HAVE PERMISSION TO CALL YOU AT WORK ( ) YES ( ) NO
WORK PHONE ___________________________

7) MAY WE LEAVE A MESSAGE ON YOUR WORK VOICE MAIL? ( ) YES ( ) NO
MAY WE LEAVE A MESSAGE ON YOUR WORK NUMBER REQUESTING THAT YOU RETURN OUR CALL? ( ) YES ( ) NO

IF ANY OF THE ABOVE INFORMATION CHANGES, IT IS THE PATIENT, PARENT, OR LEGAL GUARDIAN RESPONSIBILITY TO CONTAC TOUR OFFICE.

PATIENT/PARENT/LEGAL GUARDIAN
SIGNATURE _______________________________________ DATE _____________