HIPAA FORM

Total Care ENT

KEEPING YOUR PERSONAL HEALTH INFORMATION PRIVATE

Home/daytime contact phone number: ______________________________

Do we have permission to call your home? [ ] Yes [ ] No

May we leave a message with other residents? [ ] Yes [ ] No

May we leave a message at your home on your answering machine/voice mail? [ ] Yes [ ] No

To whom at your residence may we talk to about your medical treatment:

Name: ______________________________

Relationship: ______________________________

Home #: ______________________________

Cell #: ______________________________

Other phone #: ______________________________

Is this person your emergency contact also? [ ] Yes [ ] No

If not, please list your emergency contact below:

Name: ______________________________

Relationship: ______________________________

Home #: ______________________________

Cell #: ______________________________

Other phone #: ______________________________

Do we have permission to call you at work? [ ] Yes [ ] No

Work #: ______________________________

May we leave a message on your work voice mail? [ ] Yes [ ] No

May we leave a message at work requesting only that you return our call? [ ] Yes [ ] No

If any of the above information changes it is the Patient/Parent/Legal Guardian responsibility to contact our office.

Patient/Parent/Legal Guardian Signature: ______________________________

Date: ____________________