HIPAA PATIENT COMMUNICATION FORM

Family and Friends: It is office policy of this Practice, Summit Urogynecology, not to release confidential medical information regarding your treatment to family members or friends except for: (1) parent /legal guardian; (2) other persons authorized by the patient; (3) as we may reasonably infer from the circumstances (for example, if you bring a family member into the exam room, we will assume, unless you object, that this person is entitled to receive information regarding your treatment); (4) in emergency situations, or (5) other as otherwise permitted by Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friend(s) or caretakers/baby-sitters, please indicate that below, so that we may best serve you. If you do not want any of your medical or health information provided to a family member or friend please circle the "no" response. By signing below, you authorize that following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this IN WRITING to our staff.

You may cancel this authorization to the extent allowed by law. If you do, you understand that the doctor or Practice may have already released information about you after you gave permission. You understand that cancelling this authorization would not prohibit any release of information by the Practice in reliance on your original authorization.

If you wish to cancel or change this agreement, please issue a letter in writing to Summit Urogynecology.

	Health Care Information		Financial Information	
Spouse ____	☐ Yes	☐ No	☐ Yes	☐ No
Parent ____	☐ Yes	☐ No	☐ Yes	☐ No
Other Name: ____________________________________	☐ Yes	☐ No	☐ Yes	☐ No

Alternative Communications: You are also entitled to specify alternative, reasonable means of communication, if you do not want to be contacted in a certain way. I hereby request the following means of contact only:

☐ Home Phone	(______) ______-__________	May we leave a message?	☐ Yes	☐ No
☐ Cell Phone	(______) ______-__________	May we leave a message?	☐ Yes	☐ No
☐ Work Phone	(______) ______-__________	May we leave a message?	☐ Yes	☐ No

Patient/Parent/Guardian Signature ____

Print Name ____ Date____________________________