PREMIER WOMEN'S HEALTH, LLC

NAME DATE

HIPAA PRIVACY COMMUNICATION

In complying with Health Insurance Portability and Accountability Act, HIPAA, we want to make sure that we safeguard your personal infomation according to your wishes when it comes to family, friends and co-workers.

Please answer the following questions and indicate with a circle your choice:

YES / NO May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls?

YES / NO May we leave messages on your answering machine at home?

YES / NO May we leave messages on your cell phone voicemail?

YES / NO May we leave messages on your voicemail at work?

YES / NO May we discuss your appointment schedules with your spouse/partner/parent?

YES / NO May we send text messages to your cellphone?

Please list any other persons other than yourself that you would permit us to discuss your medical care or financial responsibility with upon request.

1) Name: _____Relationship: _____Phone:_____

MEDICAL CARE / FINANCIAL RESPONSIBILITY / BOTH

2) Name: _____Relationship: _____Phone:_____

MEDICAL CARE / FINANCIAL RESPONSIBILITY / BOTH

You must inform us, IN WRITING, of any changes in your directives. This will be kept in your file along with your acknowledgment of receipt of our Notice of Privacy Practices.

_____

Printed Name Signature Date

*** * * Please provide a contact number for which detailed voice/ text messages may be left * * ***

_____ _____

Phone Number Email