

## PATIENT HIPAA COMMUNICATION FORM

## Disclosure to Self and to Others

A. FAMILY AND FRIENDS: It is the office policy of SGNT not to release confidential medical information regarding your treatment to family members or friends, except for:  (i) parent/legal guardian  (ii) other persons authorized by the patient  (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment)  (iv) in emergency situations, or  (v) as otherwise permitted by the 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 anyone other than yourself, please indicate that below. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. Updates to this form must be made in person.  Name Relationship Phone  Name Relationship Phone  B. ALTERNATIVE COMMUNICATION: I wish to be contacted in the following manner.  (Check all that apply)  Home Phone Cell Phone Okay to leave message with details Leave a call back number only  Work Telephone Written Communication  Okay to leave message with details Okay to mail to home address  Leave a call back number only  Patient Portal Yes or No	Patient Name:	Date o	of Birth:	
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Note: SGNT does not use email to communicate with patients