FAGADAU HAWK & SWANSON M.D. | Vision. For Life.

## Patient Preference Regarding Communication of Health Information

**The purpose of this document is to protect your privacy**.

In order to better protect your privacy under **HIPAA**, and to comply with all **HIPAA** regulations, we have created this consent form for releasing medical information to family members and other people of choosing. This will also be used for consent to leave detailed phone messages at the mentioned phone numbers, mail any test results to your personal email address and/or home address.

Many times we have patient's family members call requesting medical information and/or appointment information. We are not allowed to release this information without the patient's written consent.

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## Communication to Family Members, Spouses or Other:

I, _____ DOB _____, hereby give my permission for the release of medical information regarding appointments and questions about my condition and treatments to the following person:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

____ Check here if you do not give permission for any additional family members, relatives or close personal friends to have access to any information regarding your medical condition (s).

## Electronic Communication via Email and/or Text

In choosing to allow us to communicate with you via email and text, please consider privacy implications; for example, any other person that may have access to your cell phone or email or any other person, such as your employer, that may have the right and/or ability to review all email or text received at your work address or work phone.

**Email is required if you would like to receive updated appointment information.**

_____ Check here if you choose to be contacted by email or text.

_____ Check here if you choose to **not** be contacted by email or text.

If you choose to allow us to contact you by email, please enter in the space below the email you would like us to use.

Email Address: _____

## Communication via the Telephone:

Detailed messages regarding my health information, appointments, etc. may be left on voicemail at the following phone numbers:

_____ (work/ cell/home) _____ (work/ cell/home)

## Consent and Agreement

I have carefully reviewed this document and our ***Notice of Privacy Practices (NPP***) and agree to fully comply with the guidelines defined herein for the communication of my health information.

Signature: _____ Date: _____