PATIENT HIPAA COMMUNICATION FORM

Disclosure to Self and to Others

Patient Name: _____

A. FAMILY AND FRIENDS:

It is the office policy of O'Hara Family Chiropractic 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 family members, friends, or caregivers/babysitters, please indicate that below, so that we may best serve you. 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
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 _____ Okay to leave message with details
_____ Leave a call back number only _____ Leave a call back number only

Work Telephone _____ E-mail Address _____
_____ Okay to leave message with details _____ Okay to send e-mail
_____ Leave a call back number only

X_____ _____ _____
Patient or Representative Signature Relationship to Patient Date