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, or (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 emergencies, 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. Any 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: _____
Okay to leave a message with details _____
Leave a call back number only _____

Cell phone: _____
Okay to leave a message with details _____
Leave a call back number only _____

Work phone: _____
Okay to leave a message with details _____
Leave a call back number only _____

Email address: _____
Okay to send email _____

PATIENT OR REPRESENTATIVE SIGNATURE	RELATIONSHIP TO PATIENT	DATE