Consent to Share Patient Information:

Patient Name: (Last, First, Middle)_____Email Address: _____

Address: _____ City:_____State:_____Zip Code _____

Date of Birth:_____Age_____Gender_____Preferred Language _____

Phone Number (mobile):_____Phone Number (alternate):_____

Personal Cellphone Number:_____**Preferred Email Address**_____

Employment Status: □ Student □ Full Time □Part Time Employer:_____

Emergency Contact: _____ Relationship to Patient: _____

Phone Number (mobile): Phone Number (alternate):

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule gives you the right to request how and where your healthcare provider communicates with you. We invite you to share your preferred place and manner of communication. You may change, update or revoke this information at any time, though it must be done in person. The information on this form will remain in effect for one year. You may revoke it at any time.

Print Name: _____ **Patient Signature:** _____ **Date of Birth:** _____

I prefer to be contacted in the following manner (circle/check all that apply):		
• **E MAIL:** • **Patient Portal:** • **Phone Contact:** ○ Cell Phone ○ _____ ○ Home Phone _____ • **Home:** _____	□ Email Address □ Healow □ Leave detailed message □ Leave detailedmessage □ Address _____	□ Leave message with a call back number only □ Leave message with a call back number only

We respect your right to indicate who you prefer to involve in your treatment decisions and/or with whom your information is shared.

Preferred Contacts

Please indicate the person (s) you prefer we share your information with below:

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Patient (signature):_____
Patient (print name): _____

Date:_____Time: _____

Parent or Guardian (print and sign): _____
(if patient is a minor or otherwise not able □ **Power of attorney on file**)