EXECUTIVE URGENT CARE
AT INDIAN WELLS

CONFIDENTIAL COMMUNICATION AUTHORIZATION

As required by the Health Information and Accountability Act of 1996 (HIPAA) you have a right to request that communications concerning your personal health information be kept confidential unless you give written authorization. I may revoke this authorization at any time, provided that the revocation is in writing to the practice.

I hereby request the use of the following, methods of communication related to my personal health, treatment or payment for treatment of:

Please select which method or methods you would like for us to communicate with you.

☐ Cell Phone ______________________ ☐ E-mail ______________________

☐ Home Phone: I want you to contact me by telephone at ______________________

- ☐ Leave messages on my answering machine.
- ☐ Do not leave messages on my answering machine.
- ☐ Leave messages with any one that answers the phone.
- ☐ Do not leave a message with any other person.

☐ Work Phone: I want to you to contact me by telephone at ______________________ ext.______

- ☐ Leave messages with whoever answers the phone.
- ☐ Do not leave a message with anyone.

☐ Mail: Send mail to the following address ______________________

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☐ E-Mail: I want to receive communication via this e-mail address ______________________

☐ Fax: I want to receive communication via fax ______________________

☐ Other: You may speak to this (these) person (s) regarding my personal health information.

______________________ ______________________
Name Phone Number

______________________ ______________________
Name Phone Number

Patient Signature ______________________ ______________________
Please print your name

Date ______________________ Witness ______________________