HIPAA POLICY

As required by the Privacy Regulations created because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we are committed to maintaining the privacy of your personal health information (PHI).

Your PHI will be used in the normal course of business for treatment and to bill you and/or your insurance company for payment of our services. Please assist us in clarifying with whom and how we may communicate information concerning your care.

**PRINT PATIENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home phone #:­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREFFERED Method of reminder notification (choose one):** 🞎**Text Message** 🞎**Home Call** 🞎**Cell Call**

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| --- | --- | --- | --- |
| AHA may remind me about a **FUTURE OFFICE APPOINTMENT**  Check all that apply…. *HOME/CELL VOICEMAIL:* **🞎YES**  **🞎NO**  *WITH ANOTHER PERSON (please list names & contact information below):* **🞎YES**  **🞎NO**  *LETTER:*  **🞎YES**  **🞎NO** | | | |
| AHA may communicate my **PERSONAL MEDICAL INFORMATION** (lab results, treatment plans, etc):  Check all that apply…. *HOME/CELL VOICEMAIL:* **🞎YES**  **🞎NO**  *WORK VOICEMAIL:* **🞎YES**  **🞎NO**  *WITH ANOTHER PERSON (please list names & contact information below):* **🞎YES 🞎NO**  *LETTER:*  **🞎YES**  **🞎NO** | | | |
| ⌧ **AHA may contact my pharmacy and obtain my past medication history.**  🞎 I prefer to not release my past medication history. | | | |
| 🞎 **Patient Portal Care Manager (indicate below):**  *(another individual you give permission to access your Patient Portal Account):*  **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| My **PERSONAL MEDICAL INFORMATION** may be discussed with the following relatives, friends, healthcare proxies, caregivers, etc. (please do not list referring physicians): | | | |
| **CONTACT NAME** | **RELATIONSHIP** | **PHONE #** | **CELL PHONE #** |
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| Please list here any *additional instructions* you may have regarding how Arthritis Health Associates handles your **PERSONAL MEDICAL INFORMATION:** | | | |

Updated 7/31/23

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: