myPRIVIA™
YOUR HEALTH YOUR WAY

Preferred Communication and Contacts

Preferred Communication:

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication.

You may update or change this information at any time; please do so in writing.

Patient Name: _____ Date of Birth: _____

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:_____**
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Cell Phone:_____**
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone:_____**
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Written Communication:_____**
- ☐ Please send all of my mail to my home address on file
- ☐ Please send all mail to THIS address:

_____
_____
_____

☐ **Other:_____**

My Preferred Contacts:

We respect your right to to tell us who you want involved in your treatment or to help with your payment issues. You may use this form to name specific individuals who you want us to share your information with; this may include information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. Please update this information in writing promptly if your preference change.

Important Note: We may share your information as set forth in our Notice of Privacy Practices to other persons not named on this form as needed for your care or treatment or the payment of services we have provided.

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

•Name:_____Telephone:_____Relationship:_____

•Name:_____Telephone:_____Relationship:_____

•Name:_____Telephone:_____Relationship:_____

Patient Signature: _____ Date: _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)