HIPAA PRIVACY CONTACT INFORMATION FORM

Associated Medical Professionals of New York takes your privacy very seriously, and would like you to review and direct your HIPAA permissions of how we may perform our business activities (such as an appointment reminder) as well as to whom you want us to communicate with.

********** Please fill out each area separately so that we are clear on your directives.**********

I, _____, give permission to Associated Medical Professionals to release the following information as noted below:

Leave appointment messages on/with:			**Leave medical information messages on/with:**		
Home Phone(include auto call)	___Yes	___No	Home Phone(include auto call)	___Yes	___No
Mobile Phone(include auto call)	___Yes	___No	Mobile (include auto call)	___Yes	___No
Mobile Text(include auto call)	___Yes	___No	Mobile Text(include auto call)	___Yes	___No
Work Phone	___Yes	___No	Work Phone	___Yes	___No
With Another Person	___Yes	___No	With Another Person	___Yes	___No
Send Via Mail	___Yes	___No	Send Via Mail	___Yes	___No
Send Via E-mail/patient Portal	___Yes	___No	Send Via E-mail/patient Portal	___Yes	___No

I authorize Associated Medical Professionals to release any information regarding appointment Information to the following individuals:

Name Relationship Phone # Cell Phone#

_____

_____

_____

I authorize Associated Medical Professionals to release any information regarding billing information to the following individuals:

Name Relationship Phone # Cell Phone#

_____

_____

_____

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I authorize Associated Medical Professionals to release any information regarding my medical history, and treatment to the following individuals:

Name Relationship Phone # Cell Phone#

_____
_____
_____

I authorize Associated Medical Professionals to release any information regarding my Medical history, and treatment in a medical emergency to the following individuals:

EMERGENCY CONTACTS: Please List Your Primary Emergency Contact First.

Name Relationship Phone # Cell Phone#

_____
_____
_____
_____

NOTE: If you have a Health Care Proxy which designates another person to make health care decisions, for you, as well as an advanced directive which outlines your health care wishes we will need a copy on file.

If you have a Power of Attorney, which designates another person to take care of your legal and financial affairs, we will need a copy for our file.

I understand that I have the right to inspect and receive a copy of the information to be disclosed, and I may revoke this authorization at any time in writing, except to the extent that action has been taken based on this authorization.

Signature_____ **DATE:** _____