## INTERNAL MEDICINE ASSOCIATES, S.C. – HIPAA COMMUNICATION PROFILE To insure compliance with current HIPAA guidelines, please provide us with the following information to confirm or establish your preferences for future confidential communications with our office. Patient's Name (Printed): \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_ Please provide your current telephone number(s) below: Work Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_Other Phone: (\_\_\_\_\_)\_\_\_\_\_ We normally contact our patients between 7 a.m. and 5 p.m. Monday through Friday. Please *check below* where you prefer to be called during these hours: Home Phone; \_\_\_\_ Work Phone; \_\_\_\_ Cell Phone; \_\_\_\_ Other Phone If we need to contact you on weekends or after hours, please check below where you prefer to be called: Home Phone; Work Phone; Cell Phone; Other Phone Your Protected Health Care Information Designees: If you are not available at the time we call, please check below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information). Please also print the name and telephone number of each designee below: \_\_\_\_\_My Spouse (Name): \_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_ My Father (Name): \_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_ My Mother (Name): \_\_\_\_\_\_ Phone: (\_\_\_\_\_) ; \_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_)\_\_\_\_\_ OTHER DESIGNEE Check here if you do not want your health care information discussed with anyone other than yourself. Confidential Voice Mail: Please check below where we have your permission to leave a confidential voice mail (e.g. lab or test results). Leave the space blank if you do not wish to receive voice mails, or if you do not have voice mail. Home Voice Mail; \_\_\_\_ Work Voice Mail; \_\_\_\_ Cell Voice Mail Confidential Fax Numbers: Please enter below only those fax number(s) where we have your permission to fax confidential health care information (e.g. lab or test results). Leave blank if you do not wish to or cannot receive confidential faxes. Home Fax: (\_\_\_\_\_) \_\_\_\_\_ Work Fax: (\_\_\_\_\_) Your signature below confirms your approval of these updated HIPAA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE SIGNED