PATIENT HIPAA COMMUNICATION FORM
Disclosure to Self and to Others

Patient Name: _____ Patient ID: _____

A. **Atlanta Perinatal Associates Patients**: It is the office policy of **MIND** not to release confidential medical information regarding your treatment to family members or friends, except for (i) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment),(iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. Updates to this form must be made in person.

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

B. **ALTERNATIVE COMMUNICATION**: I wish to be contacted in the following manner. ***(check all that apply)***

Home Phone _____

_____ Okay to leave message with details

_____Leave a call back number only

Work Telephone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Cell Phone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Written Communication

_____ Okay to mail to home address

Patient Portal Yes or No

X_____ _____ _____

Patient or Representative Signature | Relationship to Patient | Date