**Notice of Privacy Practices – Consent to Share**

At Eastern Plains Medical Clinic of Calhan, we are committed to safeguarding the privacy and confidentiality of your medical records including the personal information you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following ***(please print)***:

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Contact number(s): May we leave a **detailed** message? Y N ***(circle one)***

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list the people that we have your permission to discuss your health and/or medical records with:**

|  |  |  |
| --- | --- | --- |
| Name of person(s) | Relationship | Phone Number (if available) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

This authorization applies to the following information ***(please initial)***:

All Information \_\_\_\_\_\_ Labs \_\_\_\_\_\_ Imaging \_\_\_\_\_\_ Immunizations \_\_\_\_\_\_\_ Medication \_\_\_\_\_\_

I have been made aware and have had the opportunity to review the privacy policies of Eastern Plains Medical Clinic of Calhan.

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_