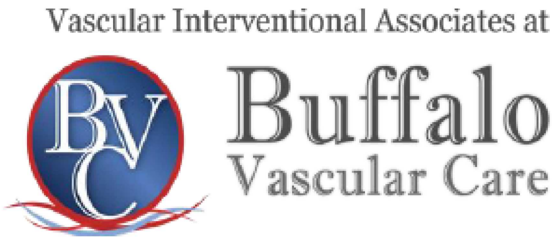

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190 Washington Avenue, Batavia, NY 14020

HIPAA Consent

Patient name:_____________________
Date of birth: _____________________

HIPAA stands for the federal Health Insurance Portability and Accountability Act**.** The primary goal of this law is to make it easier for people to keep health insurance, and to protect the confidentiality and security of a patients health care information. Essentially, what this means is that we cannot release or share any of your private health information without your consent to do so. It is required that we get your written consent to the following information.

Can we leave APPOINTMENT information on/with any of the following:
please check all that apply

☐ **Home phone**
☐ **Cell phone**
☐ **Work phone**
☐ **With my emergency contact**
☐ **Send via Mail**
☐ **Send via E-mail/Portal**

Can we leave MEDICAL information on/with any of the following:
please check all that apply

☐ **Home phone**
☐ **Cell phone**
☐ **Work phone**
☐ **With my emergency contact**
☐ **Send via Mail**
☐ **Send via E-mail/Portal**

I wish my emergency contact to be:

Name:____

Phone:____

Relationship to me:____

☐ **You may NOT contact my emergency contact nor anyone else with medical and appointment information.**
By signing below, I consent that the above selected and written information was chosen and written by me. It is accurate and my personal preference.

_________________________ _________________________
Please sign and date here