**Patient Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| I have read and understand the HIPPA/Notice of Privacy Policies for **Ohio Heart Group, Inc**. I have been given the opportunity to ask any questions I may have regarding the Notice of Privacy Policies for **Ohio Heart Group, Inc**. |
|  |

**I wish to be contacted in the following manner: (please circle all that apply)**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

It is okay to leave a detailed message with medical information. Yes No

Leave a message with a call back number only. Yes No

**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

It is okay to leave a detailed message with medical information. Yes No

Leave a message with a call back number only. Yes No

**Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

It is okay to leave a detailed message with medical information. Yes No

Leave a message with a call back number only. Yes No

**Written Communication: (Please circle one)** Yes No

Who are we allowed to speak to about your health information: (This includes but not limited to, information regarding test, lab results, prescriptions and medical instructions, etc.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PH#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PH#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if you prefer to have no one spoken to concerning your health information. \_\_\_\_\_\_

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_