

**HIPAA PATIENT CONTACT INFORMATION AND ACKNOWLEDGEMENT**

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply)

- Home Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - O.K. to leave message with detailed information on answering machine
  - O.K. to leave message with person answering phone
  - Leave message with call-back number only
  
- Work or Cellular Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - O.K. to leave message with detailed information on voicemail
  - O.K. to leave message with person answering phone
  - Leave message with call-back number only
  
- Written Communication
  - O.K. to mail to my home address
  - O.K. to mail to my work/office address \_\_\_\_\_
  - O.K. to fax to this number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  
- Other \_\_\_\_\_

PLEASE LIST THE NAME(S) OF FAMILY MEMBERS OR FRIENDS THAT YOU GIVE YOUR PERMISSION FOR US TO TALK WITH REGARDING YOUR HEALTH INFORMATION:

Name _____	Relationship to Patient: _____
Name _____	Relationship to Patient: _____
Name _____	Relationship to Patient: _____

I hereby acknowledge that I was given a copy of the Notice of Privacy Policy issued by GREATER CINCINNATI CARDIOVASCULAR CONSULTANTS, INC. on the date indicated below.

PATIENT SIGNATURE \_\_\_\_\_

PRINT PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ DATE \_\_\_\_\_

(If you have any additional or special instructions regarding contact information, please list on the reverse side of this form.)

**Note: Uses and disclosures of protective health information may be permitted without prior consent in an emergency.**