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Atkinson Family Practice

Caring for you and your Whole Family

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HIPAA

Contact/Sharing Information Consent

Patient Name: _____ DOB:_____

Address: _____ City _____ State _____ Zip _____

		May we leave a message and/or medical info?	Which number is primary for messages?
Phone (Home)	_____	**Y / N**	☐
(Work)	_____	**Y / N**	☐
(Cell)	_____	**Y / N**	☐

Do you have an email address? **Y / N**
If so, may our providers contact you at that address with possible medically sensitive details? **Y / N**
Please provide your email address by **printing clearly on the line below:**

_____

Email Address

Would you like to receive a monthly E-Mail newsletter from our office letting you know of upcoming events at the Atkinson Building, along with informative healthcare topics of interest? Y / N

Due to HIPAA regulations, we may only discuss health information with people that you have listed (*that includes parents and/or spouses*). Please list **all people** that we may speak to about you and your medical status below.

NAME	PHONE NUMBER	RELATION TO PATIENT
Dragonfly Integrated Care Group—for medical/behavioral collaboration as appropriate		

Please note that this consent will be valid for one year (from date signed)*****. If your contact information changes before the end date, please complete a new form. This may be revoked at any time, in writing. The information is for your protection and we appreciate your cooperation in protecting you and your rights.

_____ *****Date:_____

Patient/Legal Representative Signature ***Valid for one year from this date***