HUNTERDON CARDIOVASCULAR ASSOCIATES

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of ___Hunterdon Cardiology___ not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: ______________________ ___yes ___ no Ph# ______________

Parent: ______________________ ___yes ___ no Ph# ______________

Other: ______________________ ___yes ___ no Ph# ______________

______________________ ___yes ___ no Ph# ______________

______________________ ___yes ___ no Ph# ______________

Phone: ______________________

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

Okay to leave a voicemail? ❑ YES ❑ NO

PRINTED NAME ______________________________ **D.O.B.** ______________

Patient/Parent/Guardian Signature: ______________________________________

Date: ______________________

By my signature, I acknowledge that I have received the Notice of Privacy Practices of Hunterdon Cardiovascular Associates, P.A.

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FOR OFFICE USE

Changes to above authorized by patient over phone:

Change	Date	Staff Initials
______________________	_______	_______
______________________	_______	_______
______________________	_______	_______