Maryland Primary Care Physicians

PATIENT HIPAA COMMUNICATION FORM

Patient Name: _____ Date of Birth: _____

FAMILY & FRIENDS: It is the policy of MPCP 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 the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) 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 caregivers, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information, as requested, regarding your care and treatment. **Updates to this form must be made in person.**

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

ALTERNATIVE COMMUNICATION: I wish to be contacted in the following manner (check all that apply):

Home Phone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Cell Phone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Work Telephone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Written Communication

_____ Okay to mail to home address

Patient or Representative Signature	**Relationship to Patient**	**Date**