PRIME HealthCare, PC

# HIPAA PATIENT CALLING INFORMATION

Name:_____ Date of Birth:_____

**With whom do you allow us to share your personal medical information?**

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

**How may we contact you?**

**Please list in the order the way you wish to be contacted. (1-3)**

___ **Home Phone:**_____

_____ DO NOT leave a message
_____ Leave brief message, return#
_____ May leave a detailed message

___ **Work Phone:**_____

_____ DO NOT leave a message
_____ Leave brief message, return #
_____ May leave a detailed message

___ **Cell Phone:**_____

_____ DO NOT leave a message
_____ Leave brief message, return#
_____ May leave a detailed message

**If you would like to communicate with our office via email, we encourage you to sign up for MyCare. This is a secure web portal. You can do this by going to www.stfranciscare.org/mycare . There is also an app on Googleplay or the App Store called My Chart.**

**I understand that it is my responsibility to notify the office of any changes in my calling or HIPAA communication information.

**PATIENT SIGNATURE**_____ **DATE**_____