UNIVERSITY
HEALTH CARE PHYSICIANS

HIPAA QUESTIONNAIRE

Please bring with you at the time of your appointment.

PATIENT NAME: _____ DOB:_____

1. Please list the family member(s) or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name: _____ Relationship: _____ DOB: _____ Phone:_____

Name: _____ Relationship: _____ DOB: _____ Phone:_____

2. Please list the family member(s) or other person(s), if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: _____ Relationship: _____ DOB: _____ Phone:_____

Name: _____ Relationship: _____ DOB: _____ Phone:_____

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent.

_____

4. Please print the telephone number(s) where you want to receive calls about your appointments, lab and x-ray results or other health care information.

_____

5. Would you allow confidential messages be left on your telephone answering machine or voicemail?
   Yes _____ No _____

6. I am fully aware my health information will/may be transmitted by electronic transmission, secure fax transmittal, Internet or email for any continued health care needs.

_____ Date _____

Patient Signature (Guardian if under 18 years old)

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CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you hereby consent for University Health Care Physicians to use or disclose protected health information (PHI) about yourself (or another person for whom you have the authority to sign for) that is protected under federal and state law and regulations, for the purposes of treatment, payment and/or health care operations.

You acknowledge that a copy of the Notice of Privacy Practices for University Health Care System has been made available to you. The terms of the Notice of Privacy Practices may change from time to time, and you may request the most current version or view the most current version on the University Health Care System website (www.universityhealth.org/privacypractices) at any time. In connection with this Notice, you also acknowledge that you have been provided an opportunity to ask questions regarding the Notice, and its contents.

With some exception, you have the right to request that University Health Care Physicians restrict how your PHI is used or disclosed. University Health Care Physicians is not required to agree to your requested restriction(s); however, if University Health Care Physicians agrees to your requested restriction(s), the restriction is binding.

PHI is protected under federal and state laws and regulations. You have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize your PHI may be used or disclosed pursuant to this Consent and our Notice of Privacy Practices.

_____patient/authorized signer's signature and date