Avere Healthcare Clinic

PATIENT PRIVACY DIRECTIVE (Rev 9/16/11)

Patient Name: ___________________________________ **Date of Birth:** _____________________

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please provide us with the phone number(s) that we or an automated service may leave messages regarding appointments:

Name	Phone Number

Please provide us with the phone number(s) that we or an automated service may leave messages regarding treatments and/or test results:

Name	Phone Number

Please provide us with the name(s) and phone number(s) that we may talk to regarding your appointments:

Name	Phone Number

Please provide us with the name(s) and phone number(s) that we may talk to regarding your treatments and/or test results:

Name	Phone Number

Please provide us with the name(s) and phone number(s) that we may talk to regarding your billing:

Name	Phone Number

You must inform us in writing of any changes in your directive.

I acknowledge that everything above is accurate. I also acknowledge I have received a copy of the "Notice of Privacy Practices" which is in this packet.

PATIENT/GUARDIAN SIGNATURE: ________________________________ **DATE:** _________________

SIGNATURE OF OFFICE REPRESENTATIVE: ___________________________**DATE:** _________________