HIPAA and Patient Communication Policy

Patient Name _____ Date of Birth _____

Under HIPAA, we may discuss your protected health information, including **care or financial information** with individuals involved in your care if you are not present or do not have the capacity to agree or object, if in the professional judgment of a RMCC physician or other caregiver, we conclude that the disclosure is in your best interest. The disclosure is limited, in this circumstance, to protected health information that is directly relevant to that individual's involvement in your care. If you would like to identify specific individuals to whom we may make the foregoing disclosures, such as in the event RMCC is unable to reach you or in response to an inquiry, please list them here:

1)_____ 2) _____

Name phone Name phone

Communications: Please specify certain ways we may or may not communicate with you. This is to include appointment reminders, test results, prescription refills and financial communications.

Phone Number:

- ☐ Yes ☐ No Leave messages on my answering machine/voicemail
- ☐ Yes ☐ No Leave messages with any other person answering the phone
- ☐ Yes ☐ No Utilize text messaging for appointment reminders **Cell** _____ **
- ☐ Yes ☐ No Attempt to contact me via my email address

**** By providing your cell number and email you are agreeing to be contacted for appointment reminders and physician surveys.**

I understand the contact information on the Registration Form will be relied upon to communicate with me regarding my medical and financial information until such time as I notify RMCC in writing of a change.

HIPAA Acknowledgement: I acknowledge I have been provided with RMCC's Notice of Privacy Practices or with an opportunity to obtain a copy and I have declined. PLEASE SEE THE RMCC NOTICE OF PRIVACY PRACTICES FOR A COMPLETE STATEMENT OF OUR USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION AND YOUR ASSOCIATED RIGHTS. OUR NOTICE OF PRIVACY PRACTICES IS AVAILABLE ON OUR WEBSITE, **WWW.ROCKYMOUNTAINCANCERCENTERS.COM** OR AT ANY OF OUR OFFICES.

Electronic Medical Records and Prescription Access: I acknowledge that the office uses electronic medical records and may use such system to look at and prescribe medications.

_____ _____

Printed Name Date Signature of Patient/Guardian

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Reason Patient Unable to Sign/Guardian Relationship