

Date: _____

Susan M. Felber, M.D.

HIPAA FORM

Patient Name (please print): _____ Date of Birth: _____

Parent Name (if patient is under 18): _____

<p>➤ Home telephone _____</p> <p><input type="checkbox"/> Ok to leave message with detailed information</p> <p><input type="checkbox"/> Leave message with call-back information only</p> <p>➤ Work telephone _____</p> <p><input type="checkbox"/> Ok to leave message with detailed information</p> <p><input type="checkbox"/> Leave message with call-back information only</p> <p>➤ Cell Phone _____</p> <p><input type="checkbox"/> Ok to leave message with detailed information</p> <p><input type="checkbox"/> Leave message with call-back information only</p>	<p>➤ Written Communication</p> <p><input type="checkbox"/> Ok to mail to my home address</p> <p><input type="checkbox"/> Ok to mail to my work/office address:</p> <p>Work Address: _____</p> <p>_____</p> <p><input type="checkbox"/> Ok to fax to this number: _____</p> <p>_____</p> <p>➤ Authorization</p> <p>I authorize the individual listed below to have access to my medical records and discuss my personal information with the physician and the office staff.</p> <p>_____</p> <p>(Name) (Relationship)</p> <p>_____</p> <p>(Patient Signature) (Date)</p>
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Please note: Patients over the age of 18 are considered to be legal adults. Their visits and conversations with their physician are considered confidential. If your child is over 18, she must indicate in writing below if she wishes to grant access to her Private Health Information (PHI) to any member of her family.

Notice of Privacy Practices

West Suburban's Privacy Notice is available on our website: www.wswomenshealth.com, and at the front desk for patients who request a copy. Please address the following to our front desk staff: requests to review your medical records, requests for copies of your medical records, requests for amendments to your medical records, and requests for a list of disclosures of your records.

My signature below acknowledges that I have been offered a copy of the Notice of Privacy Practices from the office staff and have been informed of my rights under HIPAA.

Confidential Communications

To tell us about restrictions on release of Private Health Information (PHI) and to request confidential communications, please complete the following: (Enter phone numbers and check all that apply)

Signature

My signature below indicates my knowledge of and agreement with all of the information noted above. Further, I understand and agree that my preferences noted above will remain in effect until I choose to revoke them in writing or complete an updated HIPAA form.

Patient Signature: _____ Date: _____