HIPAA PATIENT CALLING INFORMATION

Name: ____ Date of Birth: ____________________

How may we contact you?

Home Phone: ____________________	Cell Phone: ____________________	Work Phone: ____________________
_____ DO NOT leave a message	_____ DO NOT leave a message	_____ DO NOT leave a message
_____ Leave a brief message, return #	_____ Leave a brief message, return #	_____ Leave a brief message, return #
_____ May leave a detailed message	_____ May leave a detailed message	_____ May leave a detailed message

---

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

Name: ____ Relationship: ____________________________

Phone Number: ____

Name: ____ Relationship: ____________________________

Phone Number: ____

Name: ____ Relationship: ____________________________

Phone Number: ____

***** Regarding Appointment Confirmation Only *****

Please note: As a service to our patients, Starling Physicians, PC uses an automated confirmation service to remind you of your appointment. In the event the call is not answered, a message is left with the date, time, location and provider name. If you do not wish to receive these calls or would like us to call an alternate number, such as a cell phone, please let us know. We will establish this number as your main number for the automated system to use.

______ May Call to confirm my appointments at this number: ______________________________

______ DO NOT call to confirm my appointments

*** I understand that it is my responsibility to notify the office of any changes in my call information

** **Signature:** ____ **Date:** ________________________

PLEASE TURN OVER

STARLING PHYSICIANS, PC
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ____ acknowledge that I have received a copy of Starling Physicians, PC Notice of Privacy Practices. This Notice describes how Starling Physicians, PC may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

____

(Signature of Patient, or Personal Representative) (Date)

____

(Relationship to Patient)