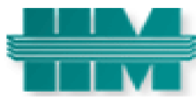

HEIGHTS MEDICAL
TODAY'S FAMILY PRACTICE SPECIALIZING IN YOU

Patient Name____

PERSONAL HEALTH INFORMATION PERMISSION

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act – HIPPA. This Federal Law prohibits any staff member of Heights Medical from discussing appointments, medications, test results or treatment plans with anyone other than the patient. Often this causes difficulty for some patients who would like family members or caretakers to obtain information for or about them. This becomes especially important if your spouse or adult children assist with making appointments for you or if you are a college student away at school and your parents assist you with prescriptions and appointments.

The law provides that you can permit one or more individuals to discuss your medical condition, confirm appointments or obtain results on your behalf. Below is a list which you may complete. Only those individuals listed may obtain information about you.

Please circle the following methods we may use to contact you:

You may leave a message:	Regarding Appointments	Regarding Medical Information	Phone #
Answering Machine at home	Yes/No	Yes/No	
With anyone at home	Yes/No	Yes/No	
Work Phone	Yes/No	Yes/No	
Cell Phone	Yes/No	Yes/No	
E-Mail	Yes/No	Yes/No	

Heights Medical Staff may discuss my medical file with the following:

Name of Individual	Relationship to Patient	Phone Number

Our e-mail complies with all HIPAA regulations regarding confidentiality. The conditions of e-mail communication are as follows:

- A signed consent by our patients is required.
- It is not to be used for urgent or emergency purposes
- All e-mail communications will become part of the patients permanent health record.
- Patients are recommended to not use work e-mails but it is their choice
- We expect to respond to e-mails within 24 hours

E-mail can be used for requesting referrals, prescription refills, to request appointments and results of tests through our website. www.heightsmedical.com

E-Mail Address: ___________________________________

Patient Printed Name: ____________________________________

Patient Signature: _______________________________________ Date: ________________