PATIENT CONFIDENTIAL COMMUNICATION

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following.

I give permission to Praxis Health to leave messages regarding:

___Appointments ___Billing

___Limited medical information, such as: normal results (Abnormal results and sensitive information will never be left on voice message), generic recommendations, medication information or referral status or updates on any of the following phone numbers listed on patient information form:

___ Home ___ Mobile ___ Work

And/Or with the following person(s):

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

This release will be revoked by written permission only. I understand that I must send a written request to Praxis Health in order to revoke this request. When translation services are utilized, you give express consent that it may be done using a wireless mobile device.
Parents/Guardians of Minor patients: this consent will expire on the patient's 18th birthday

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the practice.

Patient Name (Please Print): _____ Date of Birth: _____

Signature (Patient/Guardian): _____ Date: _____