HIPPA and Privacy Practices Document

Cary Adult Medicine, PLLC
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(919) 859-2566

I hereby ACKNOWLEDGE that I have received a copy of the Cary Adult Medicine PRIVACY PRACTICES. Further, I wish to allow for the following modifications to allow Cary Adult Medicine to contact me in the future.

HOME ANSWERING MACHINE OR MESSAGE

1. Cary Adult Medicine may leave a message on my home answering machine or cell phone **ONLY TO CALL MY DOCTORS OFFICE BACK**.

YES_____ NO_____

2. Cary Adult Medicine **MAY LEAVE ANY RESULTS/MESSAGE** (Including lab reports, test results, referral information, etc) on my home answering machine or cell phone. **YES_____ NO_____**

3. May we leave a message with spouse, parent or other? **YES_____ NO_____**

Name: _____

Relationship: _____

WORK VOICEMAIL

1. Cary Adult Medicine may leave a message on my work voicemail **ONLY TO CALL MY DOCTORS OFFICE BACK.**

YES_____ NO_____

2. Cary Adult Medicine **MAY LEAVE ANY MESSAGE** (Including lab reports, test results, referral information, etc) on my work voicemail.

YES_____ NO _____

E-MAIL/PORTAL (please realize that EMAILS may be intercept by 3rd parties)

1. Cary Adult Medicine may contact me via email/portal to **ONLY CALL MY DOCTORS OFFICE BACK ONLY.**

YES_____ NO_____

2. Cary Adult Medicine may contact me via email/portal and **LEAVE MEDICAL INFORMATION** (including lab reports, test results, referral information, etc)

YES_____ NO_____

PATIENT NAME PRINT _____

SIGNATURE_____

DATE_____

If signature is not that of the patient, indicate the relationship of person signing for the patient(e.g. parent, guardian, etc.)
(If patient or patient's personal representative does not sign, indicate the reason why signature could not be obtained) _____