Traverse Health Clinic and Coalition
D.B.A. Traverse Health Clinic

HIPAA PATIENT PERMISSIONS

Patient Name: ____ Date: ________________________

Patient Birth Date: _______________________

We take our HIPAA privacy obligations seriously. Traverse Health Clinic will use and disclose your health information consistent with what is explained our NOTICE OF PRIVACY PRACTICES (NOPP). The most common reasons why we use or disclose your health information is for treatment, payment or healthcare operations. If you wish to discuss how we use your health information as described in our NOPP, please ask to speak with the Privacy Officer or staff person. To better protect the privacy of your health information, please provide the following information:

1. **May we discuss your health information with family or friend(s)?**

   ☐**Yes** ☐ **No** If yes, identify up to 2 people below:

   A. Name: ____

   May this person pick up medications and paperwork on your behalf? ☐**Yes** ☐ **No**

   Relationship: ____

   Home Phone: __________________________________ Cell: _______________________________

   B. Name: ____

   May this person pick up medications and paperwork on your behalf? ☐**Yes** ☐ **No**

   Relationship: ____

   Home Phone: __________________________________ Cell: _______________________________

2. **Whom should we call if you have an emergency? (List 2 people)**

   A. Name: ____

   May we tell this person detailed health information about the emergency?

   ☐ **Yes** ☐ **No**

   Person's Home Phone: ___________________________ Cell: _______________________________

   B. Name: ____

   May we tell this person detailed health information about the emergency?

   ☐ **Yes** ☐ **No**

   Person's Home Phone: ___________________________ Cell: _______________________________

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Reviewed 06/2016, Revised 05/2017, Reviewed 9/2018, 1/23/19, FINAL 1-29-19

3. **How would you like us to contact you? (select all that apply)**

Home Phone OK to leave a detailed voice message? ☐**Yes** ☐ **No**

Cell Phone OK to leave a detailed voice message? ☐**Yes** ☐ **No**

Other Phone OK to leave a detailed voice message? ☐**Yes** ☐ **No**

Mail ☐**Yes** ☐ **No**

Address: ____

____

____

4. **FOR AUTOMATED (ROBO CALL) MESSAGES:**

I agree to use the following electronic services for automated messages.

(Please check each service that you agree to use)

______Automated phone message (Cell phone or land line)

______Text messages (Cell phone only)

Preferred phone number for all electronic messaging services __________________________________

______I do not want to use any of these services

Preferred Language (circle ONLY one) English Spanish

Preferred Time to Call (circle ONLY one) Morning Afternoon Evening

Patient Signature: ____ Date: ______________________

If you are signing as a parent or a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Your Name: ____

Relationship to Patient: ____

Signature: ____

Source of Authority: ____

Attach relevant documents, if applicable, such as guardianship papers, power of attorney, etc.

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