TEXAS ORTHOPAEDIC ASSOCIATES

HIPAA Compliance
Patient Preference – Communication of Health Information

Who to Contact:
I hereby give permission to Texas Orthopaedic Associates to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name ____________________ Relationship ____________________

Name ____________________ Relationship ____________________

Name ____________________ Relationship ____________________

☐ **I DO NOT** wish to give permission for family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

How to Contact:
I wish to be contacted in the following manner:

Home Telephone
- ☐ OK to leave detailed information
- ☐ Leave message with call back number only

Work Telephone
- ☐ OK to leave detailed information
- ☐ Leave message with call back number only

Written Communication:

☐ OK to mail to my home address: ____________________

☐ OK to mail to my work address: ____________________

☐ OK to fax to this number: ____________________

The duration of this authorization is indefinite unless otherwise revoked in writing.
I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Name ____________________ Date ____________________
Signature of Patient or Legal Representative

____
Printed Name of Patient or Legal Representative