Protected Health Information

I Acknowledge that the notice of privacy practices is available. (If you would like a copy of the privacy practices, please request one at the front desk)

We cannot discuss your protected health information with anyone other than yourself,unless you authorize us to do so.

You ARE NOT required to list any names if you do not choose. By listing names, you authorize **Dr.Taisenchoy-Bent's Office** to release, and discuss information related to your health condition (including information related to your treatment plan,medication information , and/or billing information). Your protected health information will be disclosed to the individual (s) listed below until you notify us otherwise in writing. This authorization will remain in effect for one year.

1._____ Relationship:_____

2._____ Relationship:_____

Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict, or expand this list at any time.

Health information Via: Email and Telephone

Please Verfiy with Front desk of your preferred contact information where you would like us to contact you for test results, appointment reminders, Scripts, or Changes to scheduled apponitments.

May we leave a detailed voicemail? Yes_____ No_____

Please be aware your email may not be Secure and ANY Health information (scripts, results, or billing information) sent via EMAIL any be compromised.

Yes: Initials: _____ Yes: I, am aware my emailed may not be secure and agree to receive my Protected Health Information electronically via email.

No: Initials _____ No: I WOULD NOT like nor agree to receive my Protected information electronically via email.

I have read and understand the above Protected Health Information (HIPPA) form.

Patient Signature_____ **Date**_____