



*An Independent Component Unit of the Eastern Band of Cherokee Indians*

**Cherokee Indian Hospital Authority**

**Caller Box C-268**

**Cherokee, NC 28719**

**PH: (828)-497-9163**

**FAX: (828)-497-3355**

## **Required Information For New Chart Packets**

- ☐ **New Chart Packet**
- ☐ **Driver's License or State ID with current 911 Address**
- ☐ **Enrollment Card/CDIB Card/EBCI First Descendant Letter**
- ☐ **Certified Birth Certificate**
- ☐ **Social Security Card/Number**

If a Driver's License or State ID cannot be provided then Proof of Residency can be established by showing documentation or two (2) of the following (Post Office Boxes are not accepted as proof):

- » Utility Bill (power, gas, telephone, etc. with physical location of home)
- » Payroll/Check stub from current employer or Per Capita showing the 911 address
- » Voter Registration Card
- » Bank Statement showing 911 address
- » Tax Return showing 911 address
- » Enrollment Card or EBCI Descendant Letter showing 911 address
- » Lease or Rental agreement showing 911 address
- » Newborns (parents need to complete a New Chart Packet and provide the required documentation listed above to Patient Registration)

**Note:** Parents have 180 days to submit newborns enrollment card or chart will be changed to Direct Care Only or Ineligible depending on parent enrollment and eligibility



## Cherokee Indian Hospital Authority Non-Established Patient/Newborn Registration Form

Health Record Number: \_\_\_\_\_ Received by: \_\_\_\_\_ Date: \_\_\_\_\_

Last Name		First Name		Middle Name
Date of Birth			Social Security Number	
Primary Language	Marital Status		Legal Sex	<b>Gender Identity:</b> <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Identify as Male <input type="checkbox"/> Identify as Female <input type="checkbox"/> Nonconforming Gender <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Other: _____
Race	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic			
Place of Birth (City, State)	<input type="checkbox"/> Tribal Land <input type="checkbox"/> Deeded Land			
Physical (911) Address				
City			State	Zip Code
Indian Blood Quantum	Tribal Membership		Tribal Quantum	Tribal Enrollment Number
Mailing Address (If different from above)			City	State
Zip Code			Present Community	
Home Phone		Work Phone		Other Phone

### Employer Information

Employer Name	Employer Phone	Employer Address
City	State	Zip Code

### Communication Information

Internet Access? <input type="checkbox"/> Yes <input type="checkbox"/> No	Email Address
<b>Internet Access Locations (Check all that apply)</b> <input type="checkbox"/> Healthcare Facility <input type="checkbox"/> Home <input type="checkbox"/> Library <input type="checkbox"/> Mobile Device <input type="checkbox"/> School <input type="checkbox"/> Tribe/Community Center <input type="checkbox"/> Work	<b>Generic Health Information</b> <input type="checkbox"/> Do we have permission to send generic health information to your email? (Check for YES)
	<b>Preferred Method of Communication (Choose One)</b> <input type="checkbox"/> Email <input type="checkbox"/> Letter <input type="checkbox"/> Phone

### Emergency Contact: Person to notify in case of Emergency

Name		Relationship	
Address		City	State
Zip Code	Phone Number		Other Phone

## Family Information

Father's Name	Father's Birth City	Birth State	Father's Employer
Father's Phone	Other Phone	Father's E-mail	
Mother's Maiden Name	Mother's Birth City	Birth State	Mother's Employer
Mother's Phone	Other Phone	Mother's E-mail	
Spouse's Name	Spouse's Date of Birth	Spouse's Employer	
Spouse's Employer Address		Employer Phone	
Number in Household		Monthly Income	

## Next of Kin

A legal Representative, over the age of 18, in the event there must be authorization given for treatment

Name	Relationship		
Address		City	State
Zip Code	Phone Number	Other Phone	

## Veteran Information

Service Branch	Service Entry Date	Service Separation Date
Did you serve in Vietnam?	Are you Disabled?	

## Insurance Information

Please provide information if you have Health Insurance-I.e., Medicare, Medicaid or other private insurances & **PRESENT YOUR INSURANCE ID CARD**

Insurance Company Name	Identification Number
Do you have custody (51% of the time) of minor children (under 18) living in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you over the age of 65, blind or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a minor (under the age of 18)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this visit pregnancy related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your employer offer Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have coverage through your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this visit related to a car accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this visit a Workmen's Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Financial Policy: If you have insurance coverage, it is your responsibility to notify the Business Office, otherwise you will be considered SELF PAY. In the event you are determined not to be eligible for service at CIHA/EBCI Programs or your health determines a service to be non-covered, or any balance remains after the insurance payment is made, you will be responsible for the complete charge remaining. IF NO OTHER ARRANGEMENTS RE MADE FOR PAYMENT, FULL PAYMENT IS DUE UPON RECEIPT OF A STATEMENT FROM OUR OFFICE.</p> <p>I have read and understand the financial policy of the Cherokee Indian Hospital as stated on this form and I agree to be bound by its terms, I also understand and agree that such terms may be amended from time to time by CIH. If I am covered by a Health Insurance Plan, I hereby authorize that my Insurance Benefits be paid directly to the CIH or EBCI Compound units, and I authorize the facility to release any information required. I certify that this information is accurate and acknowledgeable that I am financially responsible for any non-covered services, including and self-pay services.</p>	
<b>Patient/Guardian Signature:</b>	<b>Date:</b>

# NOTICE OF PRIVACY PRACTICES

This Notice is effective on April 14, 2003

Updated June 11, 2021

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION  
ABOUT YOU MAY BE USED AND DISCLOSED AND  
HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**WE ARE REQUIRED BY LAW  
TO PROTECT MEDICAL INFORMATION  
ABOUT YOU**

We understand that medical information about you and your health is personal. Any health information that can be used to identify you is “Protected Health Information” (PHI) by law. We are committed to protecting medical information about you. We create a record of the care and service you receive from us. This medical information may be about health care we provide to you or payment for this health care. It may also be information about your past, present, or future medical condition. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our program or your health care provider.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information.
- Follow the terms of this Notice that is currently in effect.

We reserve the right to make changes and to make the new Notice effective for medical information we already have about you as well as any information we receive in the future.

If we make changes to the Notice, we will:

- Post the new Notice in our waiting area.
- Have copies of the new Notice available upon request

We will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes made by your mental health professional made about a conversation during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than protected health information.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that:

- we have relied on that authorization or

- If the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you
- Explain your rights with respect to medical information about you
- Describe how and where you may file a privacy-related complaint

<p style="text-align: center;"><b>WE MAY USE AND DISCLOSE MEDICAL INFORMATION</b>  <i>ABOUT YOU IN SEVERAL CIRCUMSTANCES</i></p>
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We use and disclose medical information about patients everyday. This section of our Notice explains in some detail and gives examples of how we may use and disclose medical information about you in order to provide health care, obtain payment for that health care, and operate our business efficiently.

## 1. Treatment

We will use and disclose medical information about you to provide health care treatment to you.

*Example:* Jane is a patient at the Women’s Wellness Clinic. The receptionist may use medical information about Jane when setting up an appointment. The nurse practitioner will likely use medical information about Jane when reviewing Jane’s condition and ordering a blood test. The laboratory technician will likely use medical information about Jane when processing or reviewing her blood test results. If, after reviewing the results of the blood test, the nurse practitioner concludes that Jane should be referred to a specialist, the nurse may disclose medical information about Jane to the specialist to assist the specialist in providing appropriate care to Jane.

## 2. Payment

We use and disclose medical information about you to obtain payment for health care services that you received.

*Example:* Jane is a patient at the Cherokee County Clinic and she has private insurance. During an appointment with a nurse practitioner, the nurse practitioner ordered a blood test. The billing clerk will use medical information about Jane when she prepares a bill for services provided at the appointment and the blood test. Medical information about Jane will be disclosed to her insurance company when the billing clerk sends in the bill.

*Example:* The nurse practitioner referred Jane to a specialist. The specialist recommended several complicated and expensive tests. The specialist’s billing clerk may contact Jane’s insurance company before the specialist runs the tests to determine whether the plan would pay for the test.

## 3. Health care operations

We may use and disclose medical information about you for “**health care operations.**” These “health care operation” activities allow us to improve the quality of care we provide and reduce health care costs. For example, we may use or disclose medical information about you in performing the following activities:

- Reviewing and evaluating the skills, qualifications and performance of health care providers taking care of you.
- Providing training programs for students, trainees, health care providers or non-health care professionals to help them practice or improve their skills.
- Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities in a particular field or specialty.
- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
- Improving health care and lowering costs for groups of people who have similar health problems and

helping to manage and coordinate the care for these groups of people.

- Cooperating with outside organizations that assess the quality of the care others and we provide including government agencies and private organizations.
- Planning for our organization's future operations.
- Resolving grievances within our organization.
- Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.
- Working with others (such as lawyers, accountants and other providers) who assist us to comply with this notice and other applicable laws.

*Example:* Jane was diagnosed with diabetes. The Diabetes Program used Jane's medical information - as well as medical information from all of the Diabetes Program patients diagnosed with diabetes — to develop an educational program to help patients recognize the early symptoms of diabetes. (Note: The educational program would not use any specific patient identifiers without their permission).

*Example:* Jane complained that she did not receive appropriate health care. Cherokee Indian Hospital reviewed Jane's record to evaluate the quality of the care provided to Jane. Cherokee Indian Hospital also discussed Jane's care with its attorney.

- 4. Health Information Exchange (HIE).** NC HealthConnex is a secure electronic network that facilitates conversations between health care providers, allowing them to access and share health-related information across the state. Participation is voluntary. If patients want to prevent information from being submitted to NC HealthConnex and shared between participating health care providers, they can "Opt Out." If a patient submits an opt-out form to the North Carolina Health Information Exchange Authority (NC HIEA), access to any information related to that patient maintained in the NC HealthConnex system will be blocked to health care providers who attempt to look up that patient.

Please be aware:

- Opting out of NC HealthConnex will not adversely affect your treatment by your physician, and you cannot be discriminated against if you do decide to opt out.
- If you change your mind about participating in NC HealthConnex, you can opt back in at any time by completing a new form and checking "Rescind opt-out."
- If you choose to opt out, please complete the opt-out form linked below. Your provider may also be able to provide a form to you.

<https://hiea.nc.gov/opt-out-form-english/download?attachment>

<https://hiea.nc.gov/opt-out-form-spanish/download?attachment>

For additional information about NC Health Connex, please visit <https://hiea.nc.gov/>

- 5. Personal Health Records.** The Personal health record (PHR) is a secure web based application that provides patient access to their health care information. The PHR is accessible to any patient who receives care at Cherokee Indian Hospital and requests a PHR account. Patients may request additional information about the patient portal from patient registration.
- 6. Direct.** The CIHA may share your health information between providers and between health care providers, patients and/or patients' authorized representatives, using the DIRECT secure, web-based messaging service.

## 7. Persons involved in your care

We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is important. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.

We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

*Example:* Jane's husband regularly comes to Urgent Care with Jane for her appointments and he helps her with her medication. When the nurse practitioner is discussing a new medication, Jane invites her husband to come into the private room. The nurse practitioner discusses the new medication with Jane and Jane's husband.

## 8. SITUATIONS WHICH DO NOT REQUIRE YOUR AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION ABOUT YOU

- **Required by law:** We will use and disclose medical information about you whenever we are required by federal, state and local law. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services.
- **To overt a serious threat to health or safety:** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Public health activities:** We may use or disclose medical information about you to public health or legal authorities charged with preventing or controlling disease, injury (abuse, neglect or domestic violence) or disability (workers compensation) as required by law.
- **Health oversight activities:** We may disclose medical information about you to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include audits, investigations, inspections, and licensure.
- **Court proceedings:** We may disclose medical information about you to a court or an officer of the court (such as an attorney) pursuant to a HIPAA compliant document issued by a court of law.
- **Law enforcement:** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes.
- **Organ Donation:** We may disclose medical information about you to a coroner, medical examiner or funeral director or to organizations that help with organ, eye and tissue transplants.
- **Appointment reminders:** We may contact you with a reminder that you have an appointment for health services at our facility.
- **Treatment alternative:** We may recommend possible treatment alternatives and options that may be of interest to you, using your health information.
- **Directory:** We will use your name, general condition, religious affiliation, and location for directory purpose, unless you do not want your information listed. This information may be provided to members of the clergy and to others who ask for you by name.
- **Marketing:** We may use medical information about you to contact you in person or by other means to encourage you to use a product or service. In some instances, we may use medical information about you to send you a small promotional gift.
- **Research organizations:** We may use or disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.

- **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans' activities, national security, intelligence activities and correctional institution.
- **Case of abuse, neglect, or domestic violence:** We may use or disclose medical information about you if the information is required by law in cases of abuse, neglect, or domestic violence situations.
- **Workers compensation:** We may use or disclose medical information about you if the information is required for the processing of a worker's compensation claim under relevant law.

## 9. Authorization

Except for situations listed in Section 5, and in situations involving treatment, payment and for operations, we will not use or disclose medical information about you without "authorization" — or signed permission — from you or your personal representative. We may wish to use or disclose medical information about you and in those instances we will contact you to sign an authorization form. You may also ask us to disclose medical information and we will ask you to sign an authorization form. If you do authorize us to use or disclose your medical information for another purpose, you may revoke your authorization at any time, in writing unless your authorization was already relied upon for some action.

If you would like to receive text message of appointment reminders for CIH you will need to sign a consent form or give verbal authorization to a CIH staff person so that it can be noted in your record that you agree to receive text message reminders.

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## YOUR HEALTH INFORMATION RIGHTS

You have several rights with respect to health information about you. This section of the Notice will briefly mention each of these rights.

### 1. Right to a copy of this Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area.

### 2. Right to inspect and copy

You have the right to see or review and receive a copy of medical information about you.

If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing and you have the right to have our decision reviewed. If you would like a copy of the information, we will charge you a fee to cover the costs of the copy, supplies, labor, and postage.

### 3. Right to have medical information amended

You have the right to request an amendment to any health information that is incorrect or incomplete. To amend your medical information, you must submit a written request along with a reason for the request. We are not required to amend health information that is accurate and complete. We will provide you with information about the procedure for addressing any disagreement with the denial.

### 4. Right to an accounting of disclosures we have made

You have the right to receive an accounting (which means a detailed listing) of disclosures of health information that we have made after April 14, 2003. You may specify the time period, which may not be longer than six years. One accounting per 12 month period is free of charge, additional accountings will be subject to a fee.



The accounting will not include several types of disclosures, including disclosures for treatment, payment, or health care operations to you, certain government functions, and PHI released pursuant to an authorization or oral or incidental disclosures.

**5. Right to request restrictions on uses and disclosures**

You have the right to request, in writing, that we limit the use and disclosure of medical information about you for treatment payment and health care operations. We are not required to agree to your request.

If we do agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

**6. Right to request an alternative means or location**

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing.

**YOU MAY FILE A COMPLAINT  
ABOUT OUR PRIVACY PRACTICES**

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint by contacting the location that provided you services or with the federal government. We will not take any action against you or change our treatment of you in any way if you file a complaint.

You may bring your verbal complaint to the:  
CIHA Medical Record Administrator at 828-497-9163,  
Hotline Number: 800-455-9014  
Or contact the Sec. of Health and Human Services.

**ADDITIONAL NOTICE PROVISIONS**

**1. Acknowledgment of receipt**

We include your acknowledgement of receipt of the Notice of Privacy Practices in your Medical Record.

**If you have questions about information in this Notice or about our privacy policies, procedures or practices you can contact:**

**CIHA Medical Record Administrator at 828-497-9163 ext. 6348**

<u>X</u>	-				-	
Patient / Guarantor Signature		Date		Employee Signature		Date

Patient Name	HRN:

Cherokee Indian Hospital or EBCI components  
HOSPITAL ROAD, CHEROKEE, NC 28719  
MAIL: CALLER BOX C-268, CHEROKEE, NC 28719  
PHONE: 828-497-9163 FAX: 828-497-5343

## Service Agreement

**1. AUTHORIZATION FOR CLINICAL CARE, HOSPITAL CARE AND EMERGENCY ROOM TREATMENT:**

The undersigned voluntarily agrees to treatment and services that his/her physician deems necessary.

**2. RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW:**

Cherokee Indian Hospital or EBCI component units may disclose all or any reasonable part of the patient's record to include information pertaining to medical history, mental or physical condition, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing all or part of the hospital's charges to include but not limited to any person, insurance companies, employer, pre-admission review, utilization review, evaluation, financial audit for any other purposes reasonably related to these activities. The undersigned understands that this authorization will remain in effect, until revoked in writing.

**3. ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize payment directly to the Cherokee Indian Hospital or EBCI component units of the benefits otherwise payable to me but not to exceed the regular charges for this period of services or hospitalization. Should any insurance benefit be paid to me, I understand that it is my responsibility to forward that benefit to the Cherokee Indian Hospital or EBCI component units. Authorization is not limited to private health insurance but may include other sources such as Medicare/Medicaid, liability claims and/or reimbursements for any services I receive.

**3.5. MVA LIEN:**

**In accordance with Public Law 87-693 (42 U.S.C. - 2652-2653) and recognizing that Cherokee Indian Hospital Authority & The Eastern Band of Cherokee is the payer of last resort, I hereby agree to assign to the CIHA /EBCI, upon request, any claim I have against a third person of reasonable value for hospital, medical, surgical or dental care and treatment furnished or to be furnished to me by or at the expense of the EBCI/ CIHA as the result of any injury or disease suffered by me under circumstances creating a tort liability upon such third person to pay damages to me.**

**4. MEDICAID:**

State regulations require you to present a current identification card every time you are admitted or receive service. Every patient is required to apply for Medicaid if referred by a Physician, Benefits Coordinator, Contract Health Service or other provider. Lack of compliance with the Medicaid application process may result in a denial for Contract Health Service until an application is completed. If you do not identify yourself as a NC Medicaid recipient, you will be responsible for this bill. Services not paid or covered under the NC Medicaid program will be billed to the patient or Guardian.

**5. MEDICARE:**

This program covers hospital and other services if it is determined that it is medically necessary for the patient to be admitted or receive health care. By signing this agreement I have given this facility a "Statement of Permit for Payment of Medicare Benefits to this Provider". It is my understanding that the Professional Review Organization and its agents may receive information needed to determine benefits payable. You are expected to pay the Medicare deductible and co-insurance. If for some reason your care does not meet the requirements of your insurance, you will be responsible for the entire bill.

**6. NON-BENEFICIARY FINANCIAL AGREEMENT:**

The undersigned agrees individually as follows: That in consideration for the services rendered to the patient, he/she obligates himself/herself and the patient to pay the account in accordance with the regular rates and terms. Any cost denied by an insurance agent or other responsible party, including co-payment and deductibles would be the responsibility of the parent, patient or guardian

**7. PATIENT RIGHTS AND RESPONSIBILITIES:**

Patient Rights and Responsibilities have been explained to me and I understand my Rights and Responsibilities as a patient or guardian. Advance Directives has been explained to me and if I should have any questions, I must speak with my Physician or other designated Advance Directives liaison. Privacy Act: I have been given notice and read the Privacy Act Notice and the laws which govern my rights as a patient.

**8. CONTRACT HEALTH SERVICES:**

I have received notice of my Contract Health Service (CHS) eligibility. I fully understand my responsibility under the CHS regulations. I understand the CHS is not an insurance program or an entitlement program. I understand that I must comply eligibility guidelines established in 42CFR Part 136 Sub Part C.

**9. AGREEMENT:**

By signing this form I understand the contents of the service agreement and have received a copy. I understand the interpretation of this agreement, which was explained to me in English and/or in a common language.

X

Patient/Guarantor Signature

Date

Interviewer Signature

Date

Patient Name

HRN:



## **Parental Permission-Designation of Parent Proxy**

I \_\_\_\_\_ (parent or legal guardian name) give  
\_\_\_\_\_ (name of parent proxy) permission to bring my  
child/children to Cherokee Indian Hospital for care. This permission will remain in effect  
unless or until I return to the hospital to request that this permission be revoked.

\_\_\_\_\_ has permission to bring my child/children for care in  
the clinic or emergency room, and for any other related visits, procedures,  
immunizations or tests at Cherokee Indian Hospital.

I understand that if I have more than one child, I will need to sign a separate form for  
each child.

I understand that a copy of this permission form will be placed in my child/children's  
hospital record.

\_\_\_\_\_ (Name of child) \_\_\_\_\_ (HRN or DOB)

\_\_\_\_\_ **Signature of Parent/Guardian** \_\_\_\_\_ Date

\_\_\_\_\_ Signature of Hospital Staff Witness \_\_\_\_\_ Date

Date scanned into child's medical record: \_\_\_\_\_ Staff Initials: \_\_\_\_\_



## **Patient Confidential Communications**

Individuals have a right to request confidential communications regarding their Protected Health Information (PHI). These requests could require that communication be directed to alternative locations; such as different mailing address or phone number.

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

Record Number: \_\_\_\_\_

Home Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

\_\_\_\_\_ OK to leave a detailed message

\_\_\_\_\_ OK to leave a detailed message

\_\_\_\_\_ Leave callback name and number ONLY

\_\_\_\_\_ Leave callback name and number ONLY

\_\_\_\_\_ Text messages for appt. reminders and  
callback name and number ONLY

### **Written Communication**

Address: \_\_\_\_\_

\_\_\_\_\_ OK to mail to the above address any medical information regarding labs, billing, etc.

Other: \_\_\_\_\_

Please list any information you DO NOT want to be mailed to the address you listed above.

The privacy rule generally requires healthcare providers to take responsible steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual or for uses and disclosures for Treatment, Payment and healthcare Operations (PTO),

Please list below Individuals we may communicate with regarding your PHI without written authorization. This may include diagnoses, test results and treatment plans.

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_

Other Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_

Other Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_

Other Phone: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

Relationship if other than Self: \_\_\_\_\_ Date: \_\_\_\_\_

\*\* This document will be scanned into the patient record and remain in effect until revoked by the patient\*\*