EAST AURORA FAMILY PRACTICE

Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to request that communications concerning your personal health information be made through confidential channels. East Aurora Family Practice will not ask why you are making your request, and will make efforts to accommodate all reasonable requests. Some method of contact must be provided.

I, _____, give my permission for East Aurora Family Practice and employees to communicate information related to my personal health, as indicated below. This request super cedes any prior request for communication of information I may have made.

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East Aurora Family Practice may disclose my appointment, test results, medical condition, treatment options and financial information to person(s) listed below: (PLEASE PRINT NAMES)		
EAFP may utilize the methods checked below to communicate the above stated information:		
Telephone	Mail	Email
EAFP may utilize the following telephone numbers to contact myself or others listed above:		
Work:	Home:	
Cell Phone:	Other:	
EAFP may EAFP may not leave messages on my answering machine/voice mail		
Print Patient's Name:		
Signature:	Date:	
Print Parent/Guardian Name:	Relationship:	