

HIPAA Approved Contacts

Please list the individuals you give permission to have access to
and discuss your protected health information:

Name	Date of Birth	Phone Number	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

This form will remain in effect until a written request is received to change
or an updated form is filled out by you.

Patient Name

Account Number

Signature

Date