WEST VIRGINIA
FOOT & ANKLE
MEDICAL AND SURGICAL TREATMENT OF THE LOWER EXTREMITY

HIPAA COMMUNICATIONS CONSENT FORM

_____ _____

Patient Name ***Date of Birth***

I give permission to be contacted in the following manner (please fill in phone numbers and check all that apply)

Home Telephone #: _____ □ **Cell Phone #:**_____

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

☐ OK to leave message at home or on the cell phone with the following family members: (list name(s) and relationship to patient)_____

_____

□ **Work Telephone #:**_____

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

Appointment Reminders

Our office uses an automated appointment reminder system to contact you prior to your scheduled appointment. Please indicate your preference on how we contact you:

☐ Home Phone ☐ Cell Phone ☐ Text Message

Written Communication

☐ OK to mail to my home address ☐ OK to mail to my work address

☐ OK to fax to this number**:** _____ ☐ OK to send to this e-mail**:**_____

Communication with Other Healthcare Providers

Patient information or medical records may be communicated to other Healthcare Providers, hospitals or insurance companies if necessary.

Please list the name, address, and phone number of health care providers that you want to receive a copy of your office visit report.

Name: _____ **Name:** _____

Address: _____ **Address:** _____

_____ _____

Phone #: _____ **Phone #:** _____

_____

Patient or Legal Representative Signature **Date**

_____

(If legal representative's signature appears above, please describe relationship to the patient)