Traverse Health Clinic and Coalition
D.B.A. Traverse Health Clinic

HIPAA PATIENT INSTRUCTIONS

Patient Name: _____ Date: _____

Patient Birth Date: _____

We take our HIPAA privacy obligations seriously. Traverse Health Clinic will use and disclose your health information consistent with what is explained our NOTICE OF PRIVACY PRACTICES (NOPP). The most common reasons why we use or disclose your health information is for treatment, payment or healthcare operations. If you wish to discuss how we use your health information as described in our NOPP, please ask to speak with the Privacy Officer or staff person.

To better protect the privacy of your health information, please provide the following information:

1. **Whom should we call if you have an emergency? (List 2 people)**

   A. Name: _____

   May we tell this person detailed health information about the emergency?

   ☐ **Yes** ☐ **No**

   Person's Home Phone: _____ Cell: _____

   B. Name: _____

   May we tell this person detailed health information about the emergency?

   ☐ **Yes** ☐ **No**

   Person's Home Phone: _____ Cell: _____

2. **May we discuss your health information with family or friend(s)? ☐Yes ☐ No**

   If yes, identify up to 2 people below:

   A. Name: _____

   May this person pick up medications and paperwork on your behalf?

   ☐**Yes** ☐ **No**

   Relationship: _____

   Home Phone: _____ Cell: _____

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B. Name: _____

May this person pick up medications and paperwork on your behalf?

☐**Yes** ☐ **No**

Relationship: _____

Home Phone: _____ Cell: _____

3. How would you like us to contact you? (select all that apply)

Home Phone	OK to leave a detailed voice message?	☐**Yes** ☐ **No**
Cell Phone	OK to leave a detailed voice message?	☐**Yes** ☐ **No**
Other Phone	OK to leave a detailed voice message?	☐**Yes** ☐ **No**

Mail ☐**Yes** ☐ **No**

Address: _____

_____

_____

Patient Signature: _____ Date: _____

If you are signing as a parent or a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Your Name: _____

Relationship to Patient: _____

Signature: _____

Source of Authority: _____

Attach relevant documents, if applicable, such as guardianship papers, power of attorney, etc.

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