McKinney Comprehensive Care

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes, when it comes to your family, friends and/or co-workers.

I ______________________________________, with Date of Birth:_____________________ and Social
(Your Name Above) (Your Birthdate)
Security Number:________________________________, authorize the specific medical information below be
(Your Social Security Number)
released to:____ by person, phone or fax.
(Name of Person that would act on your behalf, if you were unable to answer questions)

____Test Results Information Only, Which may include Lab, X-Ray

____Medications

____**All Health Care information, including labs, relating to the above patient**:

____All Health Care information **including** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.

____All Health Care Information **excluding** information relating to HIV/Aids testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.

Please circle your response to the following:

May we leave messages concerning **appointments** with a co-worker, receptionist or secretary that regularly answer your calls? Yes No N/A

May we leave **messages** on a voice mail at your home? Yes No N/A

May we leave **messages** on a voice mail at work? Yes No N/A

May we discuss **appointments/treatment** with other parent/guardian? Yes No N/A

You must inform us, **in writing**, of any changes in your directives. This HIPPA notice was required to be in effect as of April 14, 2003, and will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

_______________________________________ _______________________________________
Parent/Guardian/Patient Signature Witness

____
Date