ABQ Integrative Family Medicine

Experienced Concierge Care In Albuquerque

HIPAA Policy

IF YOU WOULD LIKE TO HAVE ANY PAPERWORK MAILED TO YOU, PLEASE BRING IN A SELF-ADDRESSED, STAMPED ENVELOPES(S) THAT WE WILL KEEP IN YOUR CHART FOR THIS PURPOSE.

I,_____, acknowledge that I have received a copy of the **HIPAA** Patient Consent Form.

Signature: _____ Date: _____

PLEASE INITIAL ALL THAT YOU AGREE TO:

1._____I give permission for ABQ Integrative Family Medicine to leave a detailed health information message on my telephone. I prefer that these messages to be left on (Please write your number on which one applies)

Home Number: _____ Cell Number:_____

or _____ Either.

2._____I give permission for staff or physicians of ABQ Integrative Family Medicine to speak to:

_____ (relationship) _____,

their number: _____or speak to:

_____ (relationship) _____,

their number: _____regarding my medical treatment.

3._____I realize that using personal email is **NOT** HIPAA compliant, but I give permission to ABQ Integrative Family Medicine to communicate with me about my medical information through email.

My email address is_____

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