DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA FORM)

Today's Date:

Last Name	First Name	Date of Birth (mm/dd/yyyy)

La Pine Community Health Center may leave a voicemail for the following: (check all that apply)

☐ General info regarding your care ☐ Billing ☐ Behavioral Health ☐ Substance abuse ☐ **Do not** leave voicemails for any reason.

Use: ☐ Preferred number only ☐ Any personal number on file

Phone Number

If there is anyone that you would like to give us permission to speak with regarding your healthcare in person or by telephone, please indicate below:

HIPAA CONTACT 1

Last Name	First Name	Relationship	Phone

☐ Schedule/cancel appointments ☐ Medical Health ☐ Behavioral Health ☐ Substance Abuse ☐ Discuss **ALL** information
☐ Pick up items from LCHC including medications, hardcopy RX's, correspondence, etc.

HIPAA CONTACT 2

Last Name	First Name	Relationship	Phone

☐ Schedule/cancel appointments ☐ Medical Health ☐ Behavioral Health ☐ Substance Abuse ☐ Discuss **ALL** information
☐ Pick up items from LCHC including medications, hardcopy RX's, correspondence, etc.

Patient (or Legal Guardian) Signature **Date**

La Pine Community HEALTH CENTER