My Country Doctor

HIPAA Policy

I have reviewed this office's "Notice of Privacy Practices" which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I so request.

I have read and understand the HIPAA policy for My Country Doctor.

_____	_____	_____
Print Name	**Signature**	**Date**

<u>Patient Contact Information</u>

I understand that the office will at times need to get a hold of me during the day. I give permission to My Country Doctor **TO LEAVE DETAILS** regarding my care, test results, billing, or appointment reminders on a voicemail at the following number(s) in this order:

1. _____ **home work cell (circle one)**
2. _____ **home work cell (circle one)**
3. _____ **home work cell (circle one)**

I authorize My Country Doctor to *speak* with the following person(s) about my care:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

I understand that if I choose not to be contacted in one of these ways, I must prepare and present written notice to My Country Doctor.

_____	_____	_____
Print Name	**Signature**	**Date**