Inova™

1PROD

The Health Insurance Portability and Accountability Act (HIPAA) **Privacy Rule** gives you the right to request how and where your healthcare provider communicates with you. We invite you to share your preferred place and manner of communication. You may change, update or revoke this information at any time, though it must be done in person. The information on this form will remain in effect for one year. You may revoke it at any time.

Print Name:_____ **Date of Birth:** _____

I prefer to be contacted in the following manner (check all that apply)**:**

☐ **Patient Portal**: MyChart
☐ **Phone Contact:** Use the following numbers to contact me:

Home Phone: _____	☐ Leave message with detailed information	☐ Leave message with a call back number only
Cell Phone: _____	☐ Leave message with detailed information	☐ Leave message with a call back number only
Work Phone: _____	☐ Leave message with detailed information	☐ Leave message with a call back number only

☐ **Written Communication:** ☐ Mail to my home address ☐ Other: _____

☐ **Other:** _____

Preferred Contacts:

We respect your right to indicate who you prefer to involve in your treatment decisions and/or with whom your information is shared. Please note, however, that we may also share your information as set forth in our Notice of Privacy Practices.

Please indicate the person (s) you prefer we share your information with below:

Name: _____Phone:_____Relationship: _____

Name: _____Phone:_____Relationship: _____

Name: _____Phone:_____Relationship: _____

Patient (signature): _____ Date: _____ Time: _____

Patient (print name): _____

Parent or Guardian (if patient is a minor or otherwise not competent):

(signature): _____ Date: _____ Time: _____

(print name): _____ Relation to Patient: _____

Interpreter Information (To be completed by Inova staff, if applicable)**:**
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

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Patient Record of Disclosure- Preferred Contacts

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ Outpatient Location: _____

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