Center for Integrated Health Care

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**Approved Contacts**

|  |  |
| --- | --- |
| **Patient Name:** |  |
| **DOB:** |  |
| **Address:** |  |
| **Phone #:** |  |

In accordance with HIPAA privacy regulations, only people listed as approved contacts on a patient’s chart can be communicated with regarding your private health information, appointment status, or account status.

Please complete the following fields to include the names of whomever you approve communication with regarding your account. Pleases select which information you give permission to share with the corresponding contact.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **Relationship:** | **Phone Number:** | **Permission to share:** |
|  |  |  | **⬄**Appointment Status **⬄**Medication History/Status **⬄**Health Information/Updates **⬄**Account Balance/Status |
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|  |  |  | **⬄**Appointment Status **⬄**Medication History/Status **⬄**Health Information/Updates **⬄**Account Balance/Status |

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_