

## LINCOLN INTERNAL MEDICINE ASSOCIATES

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak with our HIPAA Compliance Officer either in person or by phone at our Main Phone Number. Signature below is only acknowledgement that you have received our Notice of Privacy Practices:

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

Please list the Person(s) to Whom Information About You May Be Disclosed. (Examples: husband, wife, son, daughter, or caregiver) Please list the **NAME AND RELATIONSHIP**. If you don't want information disclosed to anyone, please write **NONE** on the lines below.

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I authorize Lincoln Internal Medicine Associates to release my personal health information (PHI) to the above noted individuals.

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

Special Instructions, if any: \_\_\_\_\_

### How can we reach you? And/or whom can we leave messages with?

Lincoln Internal Medicine Associates may and will contact you about test results, appointments, referrals or billing/insurance information. But:

1. We will NOT leave **detailed** messages with anyone except the patient or legal guardian;
2. We will NOT leave **detailed** messages on voice mail or answering machines; or
3. We will **NOT** send emails/faxes;

unless we have written permission to do so.

Please read below and carefully consider who, if anyone, you want to have access to your medical information.

I, \_\_\_\_\_ as (circle one) patient / power of attorney / legal guardian give my permission for Lincoln Internal Medicine Associates to leave phone messages regarding appointment times and necessary information relating to my appointment. I fully understand that this consent will remain valid until revoked in writing by me.

Patient Name: \_\_\_\_\_ (Please print neatly.)

Date of Birth: \_\_\_\_\_

If we are unable to reach you, may we leave a phone message to inform you of test results or that test results are available and request that you contact our office for those results and/or treatments prescribed?

Home Phone: \_\_\_\_\_  Yes  No

Work Phone: \_\_\_\_\_  Yes  No

Cell Phone: \_\_\_\_\_  Yes  No