# Health Information Portability and Account Act (HIPAA) & Patient Communication Consent

**MICHIGAN RHEUMATOLOGY & WELLNESS CENTER** is dedicated to keeping your medical record information confidential. You should be aware that even if addressed to your physician, the staff and/or colleagues would also have access to this information. Please note - This authorization is optional and does not grant access to the patient's medical records. All requests for medical records must be authorized by the patient in writing. This allows our staff to speak to these individuals.

When sending mail, please put the subject of your message, include your name and call back telephone number in the message. We also ask that you acknowledge receipt of emails coming from this office. Communications relating to diagnosis and treatment will be filed in your medical record.

- I understand that this office will not be responsible for information loss or breaches in confidentiality that are due to factors beyond this office's control. _____ **(initials)**
- I agree to have messages left on my voicemail for appointment, billing, and non-serious health care issues _____ **(initials)**
- I understand and agree to the above electronic communication policy. _____ **(initials)**

**I wish to be contacted in the following manner:**

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Ok to leave message with details: _____ **(initials)**

**Written communication:**

Email Address: _____

Ok to mail to my home _____ **(initials)**

Ok to send email with details _____ **(initials)**

**Release of Information:** Please enter full name and date of birth and relationship to the patient for each individual.

| Full Name | Date of Birth | Relationship to Patient | Contact Phone Number | Information |
|---|---|---|---|---|
| | | | | ☐ Healthcare<br>☐ Treatment<br>☐ Billing |
| | | | | ☐ Healthcare<br>☐ Treatment<br>☐ Billing |
| | | | | ☐ Healthcare<br>☐ Treatment<br>☐ Billing |

**I request that Michigan Rheumatology and Wellness Center NOT discuss my healthcare treatment and/or billing issues with:**_____

**I understand this authorization may be revoked by me at any time and must be done so in writing. By signing below, I give permission to MICHIGAN RHEUMATOLOGY & WELLNESS CENTER to use and disclose PHI necessary to carry out treatment and/or payment. By signing this form, I understand that the privacy practices of the office have been disclosed to me.**

Signature:_____ Date: _____