



# HIPAA and Patient Communication Policy

Patient Name \_\_\_\_\_

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

Under HIPAA, we may discuss your protected health information, including **care or financial information** with individuals involved in your care if you are not present or do not have the capacity to agree or object, if in the professional judgment of POSC physician or other caregiver, we conclude that the disclosure is in your best interest. The disclosure is limited, in this circumstance, to protected health information that is directly relevant to that individual's involvement in your care. If you would like to identify specific individuals to whom we may make the foregoing disclosures, such as in the event POSC is unable to reach you or in response to an inquiry, please list them here:

1<sup>st</sup>) \_\_\_\_\_  
Name phone

2<sup>nd</sup>) \_\_\_\_\_  
Name phone

Communications: Please specify certain ways we may or may not communicate with you. This is to include appointment reminders, test results, prescription refills and financial communications.

- Phone Number:  Yes  No Leave messages on my answering machine/voice mail
- Yes  No Leave messages with any other person answering the phone
- Yes  No Utilize text messaging for appointment reminders Cell \_\_\_\_\_ \*\*
- Yes  No Attempt to contact me via the my email address

**\*\*By providing your cell number and email you are agreeing to be contacted for appointment reminders and physician surveys. We utilize third party companies such as ZocDocs and Press Ganey to provide healthcare operation services.\*\***

I understand the contact information on the **Registration Form** will be relied upon to communicate with me regarding my medical and financial information until such time as I notify POSC in writing of a change, at the address listed below.

**HIPAA Acknowledgement:** I acknowledge I have been provided with POSC's Notice of Privacy Practices or with an opportunity to obtain a copy and I have declined. PLEASE SEE THE POSC NOTICE OF PRIVACY PRACTICES FOR A COMPLETE STATEMENT OF OUR USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION AND YOUR ASSOCIATED RIGHTS. OUR NOTICE OF PRIVACY PRACTICES IS AVAILABLE ON OUR WEBSITE, [WWW.PANORAMAORTHO.COM](http://WWW.PANORAMAORTHO.COM) OR AT ANY OF OUR OFFICES.

**Electronic Medical Records and Prescription Access:** I acknowledge that the office uses electronic medical records and may use such system to look at and prescribe medications.

\_\_\_\_\_  
Printed Name Date

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Reason Patient Unable to Sign/Guardian Relationship

For further questions, or to change/revoke your information, please contact our Privacy Officer at: 303-233-1223  
Address: Panorama Orthopedics and Spine Center Website: [www.panoramaortho.com](http://www.panoramaortho.com)  
660 Golden Ridge Road, Suite 250  
Golden, CO 80401



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