PATIENT PRIVACY QUESTIONNAIRE

Please have this information available to input in our electronic check-in system.

CONTACT RECORD

Patient Name: ____ Date of Birth: ______________

Please contact me as follows: (in order of preference)

1. (____) ______-_________ Home, Work, Cell Phone, Other (circle one)
2. (____) ______-_________ Home, Work, Cell Phone, Other (circle one)
3. (____) ______-_________ Home, Work, Cell Phone, Other (circle one)

- ☐ Okay to leave messages with healthcare information
- ☐ Leave message with call back number only
- ☐ Do **NOT** leave messages
- ☐ No restrictions – speak with whomever necessary on my behalf

<u>List the names and phone numbers of individuals you authorize us to speak with regarding your healthcare:</u>

- ☐ None
- ☐ Spouse ______________________________ Phone Number____________________________
- ☐ Child ________________________________ Phone Number____________________________
- ☐ Parent ______________________________ Phone Number____________________________
- ☐ Other _______________________________ Phone Number____________________________

<u>Note:</u> If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address.

I have received a copy of Faculty Internal Medicine's Notice of Information Practices. I understand this Notice describes how my health information may be used or disclosed by FIM physicians and other providers at Faculty Internal Medicine. It is our policy that patient medical records will be given only to the patient unless specified otherwise above. This authorization does not expire unless revoked or terminated by the patient or the patient's personal representative. <u>You may revoke or terminate this authorization by submitting a written revocation to Faculty Internal Medicine.</u> I am aware the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (865) 218-9220 or on the web site at www.facultyinternalmedicine.com or by requesting one at the Faculty Internal Medicine office. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Faculty Internal Medicine discloses it to a party listed above. You may inspect or copy information used or disclosed under this authorization.

You may refuse to sign this authorization. If you refuse to sign this authorization, Faculty Internal Medicine will not deny you any treatment except research-related treatment, or treatment that you have requested for the purpose of disclosure to others.