



HIPAA CONSENT

In our efforts to comply with the Health Information Privacy Act (**HIPAA**), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please circle your choice responses to the following questions:

May we leave messages concerning your appointments/treatments with a co-worker, receptionist or secretary that regularly answers your calls?	YES	NO
May we leave messages on a voicemail at work?	YES	NO
May we leave messages on an answering machine at home?	YES	NO
May we leave messages on your cell phone?	YES	NO
May we leave messages with a spouse or significant other?	YES	NO
Is there anyone that is not listed above that we can give information to? If so, please specify.	YES	NO

For any children above the age of 18, still living at home, may we discuss

your appointments/treatments with your parent(s) or Guardian?	YES	NO
I would like to receive regular email updates and/or newsletters:	YES	NO

Email address

You must inform us, in writing, of any changes in your directives. This record will be kept in your file with your acknowledgement of receipt of our Notice of Privacy Practices.

Signature of Patient **Date:** _____

Signature of Patients Parent/Legal Guardian, if Patient is Under 18 **Date:** _____

Revive Primary Care and Med Spa Staff **Date:** _____