Sherwood Family Chiropractic

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HIPAA Communications

Patient Name: _____ Date of Birth:_____

The communication can be delivered by the following (Please ✔ if permissible):

Appointment Message	**Medical Information**
___ Home Phone	___ Home Phone
___ Cell Phone	___ Cell Phone
___ Text Message	___ Text Message
___ Work Phone	___ Work Phone
___ With Someone Listed Below	___ With Someone Listed Below

Contact Information:
Home Phone #: _____
Cell Phone#: _____
Work Phone #: _____

Would you like reminders (text or email)?
___ **Yes:** (select your preference below)
___ Text Message ___ Email
___ **No.**

I give permission to Sherwood Family Chiropractic staff to discuss with the following listed individual(s), information reasonably deemed to be directly related to such individual's involvement on the above referenced patients' health care.

Name:_____
Relationship to Patient:_____
Phone #:_____

Name:_____
Relationship to Patient:_____
Phone #:_____

Name:_____
Relationship to Patient:_____
Phone #:_____

Name::_____
Relationship to Patient:_____
Phone #: _____

Email Confidentiality Notice: Email transmission is not secure and should not be used for confidential or privileged communications. Because email can be altered electronically, the integrity of the communication cannot be guaranteed.

I understand that I may change the above information at any time. Any change requested does not affect any communication previously made in reasonable reliance on this form. I have had the opportunity to receive and read the Sherwood Family Chiropractic Notice of Privacy Practices.

_____ _____ _____

Patient Name **(Printed)** Patient Name **(Signature)** Date