FOUR PEAKS NEUROLOGY PRIVACY PRACTICES AND INSTRUCTIONS FOR DISCUSSING PERSONAL HEALTH INFORMATION

Patient Name: _____Date of Birth: _____/_____/_____

___ (please check) I have received and read the noted of Privacy Practices (HIPPA) form.

Instructions for Discussing my Personal Health Information with Others: I give permission for the following individuals to receive and/or discuss my medical care with any and all providers and employees affiliated with Four Peaks Neurology.

1. _____
   Name and Relationship to Patient

2. _____
   Name and Relationship to Patient

3. _____
   Name and Relationship to Patient

Communication Request: I request that all communication with me by telephone, mail, or otherwise by Four Peaks Neurology and/or its staff be handled in the following manner: (please check all that apply)

___ You may leave a message on my answering machine.

___ You may leave a message with _____

___You may TEXT

___You may mail me.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Legal Representative **Relationship to Patient**