Appalachian Foot and Ankle Associates, P.A.

Request for Confidential Communications and Patient Acknowledgement of Receipt of Notice of Privacy Practices "HIPAA"

I request Patient Portal Access with the following email address: _____

☐ I do not want access to the patient portal.

I authorize Appalachian Foot and Ankle Associates to release my confidential protected health information (PHI) to:

Please fill in the name and relationship and check the applicable box(es):

Emergency Contact: _____ Phone: _____ Relationship: _____
Information to be released: ☐ ANY ☐ NONE ☐ AS FOLLOWS: _____

Other: _____ Phone: _____ Relationship: _____
Information to be released: ☐ ANY ☐ NONE ☐ AS FOLLOWS: _____

I grant the authority to Appalachian Foot & Ankle Associates, P.A to download and share medical records and medication history automatically with connected care locations and pharmacy benefit managers. _____ (Please sign or initial)

I request automated communication to be made in one or more of the following ways:

Health Notifications:	☐ Email	☐ Phone	☐ Text Message
Appointment Reminders:	☐ Email	☐ Phone	☐ Text Message
Office Announcements:	☐ Email	☐ Phone	☐ Text Message
Billing Information:	☐ Email	☐ Phone	☐ Text Message

☐ *I prefer not to receive any of the above communication through email, phone, or text message.*

I request that all other communications to be made in the following ways:

Leave message on my home answering or cell voicemail:	☐ YES	☐ NO
Leave message with persons answering my home or cell number:	☐ YES	☐ NO
Leave message at my work number:	☐ YES	☐ NO
Correspondences be mailed to my home address:	☐ YES	☐ NO

I acknowledge that upon request I am entitled to a copy of Notice of Privacy Practices and that I have read or had the opportunity to read if I so choose, and understand the notice.

_____ _____

Signature of Patient, Parent/Guardian, or Power of Attorney Date