virginia beach diagnostics

PREFERRED COMMUNICATION

v1.1

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communicatio. **You may update or change this information at any time; please do so in writing.**

Patient Name: _____ Date of Birth: _____

I prefer to be contacted in the following manner (check all that apply):

☐ Send all commuication through my Patient Portal.

☐ Home Phone:_____

- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with call-back number only

☐ Cell Phone: _____

- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with call-back number only

☐ Work Number: _____

- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with call-back number only

☐ Written Communication: _____

- ☐ Please send all of my mail to my home address on file
- ☐ Please send all mail to THIS address:

_____

_____

_____

☐ Other: _____

My Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results, **YOU,** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below. **Please update this information in writing promptly if your preferences change.**

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experence Team at 205-246-1079 - Monday - Friday 8am - 5pm EST.

Name:_____ Telephone:_____Relationship:_____

Email:_____

Name:_____ Telephone:_____Relationship:_____

Email:_____

Name:_____ Telephone:_____Relationship:_____

Email:_____

ACKNOWLEDGEMENT: I understand that HIPPA may require my provider to share my information with other persons **not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature:_____ Date:_____

(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)