

**Monmouth Family Foot and Ankle, LLC**

**Health Insurance Portability and Accountability Act (HIPAA) Form**

In our efforts to protect your privacy, please identify the person/persons with whom we may discuss your care:

Name:

Telephone:

Relationship to patient:

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I do not wish to have my care discussed with anyone other than myself

**Telephone Communication**

PLEASE CHECK ONE OPTION BELOW

Home Telephone Number: \_\_\_\_\_

OK to leave message with detailed information

Leave message with callback numbers only

PLEASE CHECK ONE OPTION BELOW

Cell Telephone Number: \_\_\_\_\_

OK to leave message with detailed information

Leave message with callback numbers only

Ok to send text message with appointment information

**Email Communication**

Email Address: \_\_\_\_\_

Ok to send email with appointment information

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth