GLPP | GREAT LAKES PHYSICIAN PRACTICE

HIPAA Contact Information

THE FOLLOWING ARE WAYS GREAT LAKES PHYSICIAN PRACTICE, PC (GLPP) MAY COMMUNICATE INFORMATION WITH YOU. PLEASE MARK YOUR PREFERENCES BY CHECKING EITHER "YES" OR "NO" FOR EACH OPTION. IF LEFT BLANK, THAT OPTION WILL AUTOMATICALLY BE CHECKED "YES" IN YOUR RECORD.

BY SIGNING THIS FORM, YOU UNDERSTAND THAT PERMISSION TO CONTACT YOU VIA U.S. POSTAL SERVICES 'MAIL' IS *MANDATORY* AND IS AUTOMATICALLY CHECKED "YES".

Patient Name _____ DOB _____

Patient Signature *(Parent/Guardian if minor)* _____ Date _____

I GIVE PERMISSION TO LEAVE *APPOINTMENT* INFORMATION:

	YES	NO
Home Phone (include auto call)		
Cell Phone (include auto call)		
Mobile Text (include auto call)		
Work Phone		
With Another Person		
Sent via Mail	XX	
Send via Patient Portal		

I GIVE PERMISSION TO LEAVE *ROUTINE AND/OR NORMAL TEST RESULTS:*

	YES	NO
Home Phone (include auto call)		
Cell Phone (include auto call)		
Mobile Text (include auto call)		
Work Phone		
With Another Person		
Sent via Mail	XX	
Send via Patient Portal		