

**PULMONARY INTERNISTS
NOTICE OF PRIVACY PRACTICES
&
PERMISSION OF PATIENT CONTACT**

MY SIGNATURE BELOW INDICATES THAT I HAVE RECEIVED AND REVIEWED THE
PULMONARY INTERNISTS NOTICE OF PRIVACY PRACTICES.
PERMISSION OF PATIENT CONTACT (VERSION 2 EFFECTIVE AUGUST 1, 2013)
PLEASE PROVIDE AT LEAST TWO NUMBERS WHERE OUR STAFF CAN CONTACT YOU:

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE _____

IN THE EVENT THAT WE CANNOT CONTACT YOU AT EITHER, MAY WE LEAVE A MESSAGE ON
ANY OF THESE NUMBERS?

HOME ___ YES ___ NO WORK ___ YES ___ NO CELL ___ YES ___ NO

CAN WE USE THE US POSTAL SERVICE TO CORRESPOND WITH YOU? ___ YES ___ NO

NOTE: DUE TO PRIVACY LAWS, WE ARE NOT PERMITTED TO DISCUSS YOUR HEALTHCARE
INFORMATION WITH ANYONE NOT LISTED BELOW:

NAME: _____ RELATIONSHIP _____

NAME: _____ RELATIONSHIP _____

NAME: _____ RELATIONSHIP _____

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE _____