

**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:** (effective April 7, 2003 under federal law)

**Please provide at least two numbers where our staff might 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      **cell** \_\_\_yes\_\_\_no      **work** \_\_\_yes\_\_\_no

**Can we use the US Postal Service to correspond with you?** \_\_\_yes\_\_\_no

**Please provide the name(s) of any person(s) that you would permit us to discuss your medical status.**

**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** \_\_\_\_\_

**Printed Name of Patient:** \_\_\_\_\_

**Patient  
Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_