KNEPPER
CONCIERGE MEDICINE
ELEVATING HEALTHCARE, ONE PATIENT AT A TIME

My Preferred Contacts

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home.

Patient Name: _____ Date of Birth: _____

(Print Clearly)

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. You may use this form to name specific individuals who you want us to share your information with; this may include information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up, and scheduling appointments. **Please update this information in writing promptly if your preferences change.**

Important Note: We may share your information as set forth in our Notice of Privacy Practices to other persons not named on this form as needed for your care or treatment or the payment of services we have provided

Please indicate the person(s) you prefer we share your information with below. If you want us to communicate using email, please provide an e-mail address and read the Note below"

- **Full Name:** _____ **Telephone:** _____

  Relationship: _____ **Email:** _____

- **Full Name:** _____ **Telephone:** _____

  Relationship: _____ **Email:** _____

- **Full Name:** _____ **Telephone:** _____

  Relationship: _____ **Email:** _____

NOTE: If I have provided e-mail addresses for my Preferred Contacts, my signature below indicates that I understand and acknowledge that e-mail communication is not secure. E-mail can be intercepted during transmission; and 2) unencrypted messages (and any attachments) can be read, and potentially copied and forwarded, by anyone. Unencrypted emails can also be easily viewed by someone other than the recipient if, for example, I access messages via a smart phone or tablet.

Patient Signature: _____ **Date:** _____ *(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)*