

# Denver Digestive Health Specialists

## HIPAA CONTACT FORM

Home (    ) \_\_\_\_\_ May we leave a message? \_\_\_Yes \_\_\_No

Work (    ) \_\_\_\_\_ May we leave a message? \_\_\_Yes \_\_\_No

Cell (    ) \_\_\_\_\_ May we leave a message? \_\_\_Yes \_\_\_No

May we fax records to your Home \_\_\_Yes \_\_\_No or Work \_\_\_Yes \_\_\_No

Can we email you? \_\_\_Yes \_\_\_No

If yes email address \_\_\_\_\_

### Who may we talk to on your behalf about medical issues?

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

### Who may we or any authorized A/R management company/agent talk to on your behalf about billing issues?

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Print Name: \_\_\_\_\_

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

Signature: \_\_\_\_\_

Date: \_\_\_\_\_