Patient Name: _____Date: _____

A. Family and Friends. It is the office policy of **Dixitkumar N Modi MD PA d/b/a Premier Medical Clinic** not to release confidential medical information regarding your treatment to family members or friends, (i) except for parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, that you do not mind that person to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on or make changes to the form, please confirm this in writing).

Name	Relationship to self/patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

□ CONSENT DECLINED

B. If we are not able to speak with you directly by phone, is it ok to leave a detailed message that may or may not contain personal medical information?

Okay to leave detailed voicemail?

□ Yes (Please specify phone number) _____

□ No thank you

By my signature, I acknowledge that I have received the Notice of Privacy Practices of **Dixitkumar N Modi MD PA d/b/a Premier Medical Clinic.**

X_____ Date: _____

OFFICE USE ONLY

Signature of staff updating in chart

_____ Date: _____