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ASSOCIATED PEDIATRICS OF
FOX VALLEY
HELPING BUILD HEALTHY FAMILIES EVERY DAY

Health Information Privacy Protection Form

All patients 18 years and over (and emancipated minors have the right to restrict communication regarding their health issues. This form allows you to specify to whom we may communicate your protected health information.

Patient's Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: ___ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Other than yourself to whom may we communicate your health information?

○ No One
○ Spouse Name: _____
○ Parents Name: _____
○ Other Name: _____

Other than your own address where can we send your protected health information?

○ No One ○ Other Address: _____
City: _____ State: ___ Zip Code:_____

Other than your own phone number where may we leave your protected health information?

○ No One ○ Other Phone: _____

I understand it is my responsibility to inform APFV immediately if I change my mind about any of the above information by completing a new Health Information Privacy Protection Form.

Signature: _____ Date: _____/_____/_____

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