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HIPAA PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Arrhythmia Consultants of Connecticut not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonable infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled 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. By signing below, you authorize the following people to receive information regarding your treatment or care: (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse:		yes	no
Parent:	<u> </u>	yes	no
Other:		yes	no
		yes	no
		yes	no
B. Alternative Communication. You are also entitled communication, if you do not wish to be contacted. I hereby request the following means of contact only:	ed by us in a certain	n way.	
PRINTED NAME		_	
Patient/Parent/Guardian Signature: Date:			
Changes to the above authorized by patient over the phor Change:		Sta	aff Initials