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MICHIGAN INSTITUTE for NEUROLOGICAL DISORDERS

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**PATIENT HIPAA COMMUNICATION FORM**  
*Disclosure to Self and to Others*

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_

- A. **FAMILY AND FRIENDS**: It is the office policy of **MIND** 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 reasonably 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 the person is entitled to receive information regarding your treatment),(iv) in emergency situations, or (v) 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 caregivers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. Updates to this form must be made in person.

Name	Relationship	Phone
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Name	Relationship	Phone
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Name	Relationship	Phone
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- B. **ALTERNATIVE COMMUNICATION**: I wish to be contacted in the following manner.  
(check all that apply)

**Home Phone** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_

\_\_\_\_\_ Okay to leave message with details

\_\_\_\_\_ Okay to leave message with details

\_\_\_\_\_ Leave a call back number only

\_\_\_\_\_ Leave a call back number only

**Work Telephone** \_\_\_\_\_

**Written Communication**

\_\_\_\_\_ Okay to leave message with details

\_\_\_\_\_ Okay to mail to home address

\_\_\_\_\_ Leave a call back number only

**Patient Portal**      Yes    or    No

X \_\_\_\_\_  
**Patient or Representative Signature**

\_\_\_\_\_  
**Relationship to Patient    Date**