**Hansen Family Practice, LLC**

**Patient Contact Information**

I understand that the office will at times need to get a hold of me during the day. I give permission to Hansen Family Practice, LLC **TO LEAVE DETAILS** regarding my care, tests results, billing, or appointment reminders on a voicemail at the following numbers(s) in this order:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Work Cell (circle one)
2. ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Work Cell (circle one)
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Work Cell (circle one)

I authorize **Hansen Family Practice, LLC** to *speak* with the following person(s) about my care:

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

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

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

**I understand that if I choose not to be contacted in one of these ways, I must prepare and present written notice to Hansen Family Practice, LLC.**

**HIPPA POLICY**

**I have read and understand the HIPPA policy for Hansen Family Practice, LLC**

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Printed Name Signature Date