

HEALTH PARTNERS Free Clinic  
HIPPA QUESTIONNAIRE

1. Please list family members or other persons that we can talk to about your general medical condition, diagnosis, appointments, lab and x-ray results, or other health care information. \_\_\_\_\_  
\_\_\_\_\_
2. Who is your Emergency Contact? What is their phone number?  
\_\_\_\_\_  
\_\_\_\_\_
3. Can we share information about your general medical condition or appointments with your work or school? YES \_\_\_\_\_ NO \_\_\_\_\_  
Please list \_\_\_\_\_
4. Please print the address of where you would like your mail from our office sent.  
\_\_\_\_\_  
\_\_\_\_\_
5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information. \_\_\_\_\_.
6. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL" Yes \_\_\_\_\_ NO \_\_\_\_\_
7. Can messages (i.e. appointment reminders, lab results or other health care info) be left on your home answering machine or voicemail? YES \_\_\_\_\_ NO \_\_\_\_\_
8. If you do not have voicemail at home, can a message be left at your place of employment?  
YES \_\_\_\_\_ NO \_\_\_\_\_

Please Print: Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient/Guardian Signature (Required) \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_