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: _____

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