ABQ INTEGRATIVE FAMILY MEDICINE

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IF YOU WOULD LIKE TO HAVE ANY PAPERWORK MATILED TO YOU, PLEASE BRING IN A SELF-ADDRESSED, STAMPED ENVELOPES(S) THAT WE WILL KEEP IN YOUR CHART FOR THIS PURPOSE.

I, _____,
ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPAA PATIENT CONSENT FORM.

_____
_____
SIGNATURE DATE

PLEASE INITIAL ALL THAT YOU AGREE TO:

_____I GIVE PERMISSION FOR DR. MARCUS HIGI MD TO LEAVE DETAILED HEALTH INFORMATION MESSAGES ON MY TELEPHONE. I PREFER THESE MESSAGES TO BE LEFT ON (PLEASE WRITE YOUR NUMBER ON WHICH ONE APPLIES)
_____HOME NUMBER, _____CELL NUMBER, _____OR EITHER.

_____I GIVE PERMISSION FOR DR MARCUS HIGI MD TO SPEAK TO _____MY
(RELATIONSHIP) _____THEIR PHONE NUMBER_____OR SPEAK TO
_____
(RELATIONSHIP)_____THEIR PHONE NUMBER_____ REGARDING MY MEDICAL TREATMENT.

I REALIZE THAT USING PERSONAL EMAILS IS **NOT** HIPAA COMPLIANT, BUT I GIVE PERMISSION TO DR. HIGI TO COMMUNICATE WITH ME ABOUT MY MEDICAL INFORMATION THROUGH EMAIL.

MY EMAIL ADDRESS IS
_____