

# Lincoln Surgical Associates, APMC

## HIPAA Information Communication Form

Lincoln Surgical Associates, APMC has a legal, ethical, and moral obligation to protect the confidentiality of our patients. In compliance with the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule, patients have a right to receive their confidential Protected Health Information (PHI). Please assist us by checking the method(s) in which you would like to have your PHI communicated to you. Thank you in advance for your assistance.

**1. My confidential health information regarding my Office visit may be communicated in the following manner:**

May leave message on answering machine

May be given to family member

May be given to friend or significant other

May be sent via e-mail

E-mail address: \_\_\_\_\_

**Note: Please list Name(s) of who may accept your personal health information:**

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**2. During hospitalization or post-surgery, my personal health information may be communicated in the following manner:**

With my Spouse

With my Parents

With my Children

With my Friend(s)

With my Family

**Note: Please list Name(s) of whom your personal health information may be discussed with:**

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**\*Except in cases of emergency and in accordance with HIPAA compliance,  
You may revoke or change this at your discretion.**

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**Signature**

**Date**