Privacy Questionnaire

Patient Full Name: _____

DOB: _____ Current Address: _____

Please review and answer the following questions in regards to your protected health information (PHI).

The contact information and phone numbers you provide will be used as agreed to below. Please note that the information will be in effect for both PREventClinic Providers and PREventClinic locations as applicable.

1. • I give PREventClinic, Inc permission to **leave a detailed message** regarding my healthcare on the phone number provided below:

   Phone number:_____
   Phone number: _____
   - No please only leave a callback name and number when you attempt to reach me.

2. • I give PREventClinic, Inc permission to message me using **text messaging (SMS, MMS)** regarding my healthcare or clinic updates on the phone number provided below:

   Phone number:_____
   Phone number: _____
3. • I give permission to discuss my medical information with the following individuals:

• Name: _____Relationship: _____

• Name: _____Relationship: _____

Authorization Signatures:

Your signature below further indicates your understanding that this authorization will be valid for a period of one year from today's date and will expire at that time unless another form is completed. You may revoke or request changes to this authorization at any time by completing a new Privacy Questionnaire.

_____ _____
Patient/Legal Representative Signature. Date Time

_____ _____
Patient/Legal Representative Name (**PRINT**) Date Time