UT RHEUMATOLOGY
A Department of the University of Tennessee Medical Center
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HIPAA PATIENT PRIVACY QUESTIONNAIRE

Patient Name:_____

1. May we leave confidential messages regarding appointments, return calls for test results, etc. on your home answering machine or voice mail?

   Yes No

   If yes, please list in order of preference where we are able to leave confidential messages regarding appointments, return calls for test results, etc.

   Phone Number: _____ Home Mobile Work
   Phone Number: _____ Home Mobile Work
   Phone Number: _____ Home Mobile Work

2. If we are unable to reach you by any of the above options, may we leave confidential messages at your place of employment?

   Yes No

   If yes, please provide place of employment and individuals we are able to leave confidential messages with.

   Employer:_____ Individual(s):_____
   Relationship:_____ Phone Number:_____

3. May we give confidential information to individuals you designate regarding appointments, lab results or other healthcare information?

   Yes No

   If yes, please list individual(s) below:

   Name:_____ DOB:_____
   Relationship:_____ Phone Number:_____
   Name:_____ DOB:_____
   Relationship:_____ Phone Number:_____

If we are unable to reach you by any other means, we will send information through the US Postal Service to your home address.

_____ _____
Signature of patient (or guardian if under age 18) Date

I have received a copy of the University Physician Associations Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by UPA, physicians and other providers practicing at UPA facilities and that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by call (865) 544-9118, by visiting www.utmedicalcenter.org or by requesting one at a UPA office.

_____ _____
Signature of patient (or guardian if under age 18) Date