UB|MD PRIMARY CARE

# HIPAA CONTACT FORM

**UBMD PRIMARY CARE OF AMHERST**
850 Hopkins Road
Williamsville, NY 14221

**UBMD PRIMARY CARE AT CONVENTUS**
1001 Main Street, 4th Floor
Buffalo, NY 14203

**UBMD PRIMARY CARE AT SHERIDAN**
2465 Sheridan Drive
Tonawanda, NY 14150

**UBMD PRIMARY CARE - ADDICTION MEDICINE**
850 Hopkins Road
Williamsville, NY 14221

| **Patient Name:** | **Date of Birth:** / / | **Email Address:** |
|---|---|---|

## RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the UBMD Primary Care Notice of Privacy Practice (also available at UBMDPRIMARYCARE.COM).

| Signature: | Date: / / |
|---|---|

☐ Patient refused and/or unable to sign.
Staff member signature:

## AUTHORIZATION TO RELEASE INFORMATION TO FAMILY AND/OR FRIENDS

**(BE SURE TO INCLUDE YOURSELF)**

| Name | Relationship | Primary Phone | Secondary Phone |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## AUTHORIZATION TO LEAVE MESSAGES

From time to time it may be necessary to leave you a message concerning appointments, financial issues, or other protected health information (PHI). Please indicate how you prefer we leave a message for you.

| | Phone Number | May we leave a voice message? | May we leave a message with another person answering this phone? |
|---|---|---|---|
| Voice Mail on Preferred Phone Number | - - | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Voice Mail on Alternate Phone Number | - - | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | May we send a message? | |
| Send through US Mail | | ☐ Yes ☐ No | |

## RESTRICTIONS TO RELEASE OF INFORMATION

Please list any restrictions regarding information to be released:

## SIGNATURE

| Signature: | Date: / / |
|---|---|

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Revised 03.28.2024