COLLABORATIVE HEALTH OUTREACH OF VIRGINIA

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www.chovawellness.com
Wellness You Can Feel.

Patient Name:_____

CONSENT TO CONTACT

In accordance with the HIPAA Privacy Rule and our own policy, Collaborative Health Outreach of Virginia (CHOVA) cannot contact the patient and/or leave messages without the patient's or guardian's consent. Please check **ONE** of the following statements to indicate your preference for contact.

□ CHOVA **MAY NOT contact me** by phone/email/text and/or leave a message.

□ CHOVA **MAY contact me** by phone/email/text and/or leave a message.

Signature: _____ **Relation to Patient:** _____ **Date:** _____
(Parent or legal guardian if client is under the age of 18.)

Please list below the person(s) CHOVA may contact on your behalf or discuss relevant medical information. We will attempt to contact you first, but in the event we can not reach you, we may contact the following people or if in the event, discuss your medical information.

NAME:_____Relationship:_____

NAME:_____Relationship:_____

NAME:_____Relationship:_____

NAME:_____Relationship:_____

NAME:_____Relationship:_____

NAME:_____Relationship:_____

Acknowledgement of Receipt of Notice Of Privacy Practices

I, _____, have received from CHOVA a copy of the "Notice of Privacy Practices". I understand that CHOVA may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring for my treatments, for obtaining payment for the services rendered to me and for the operations of this practice. I consent to the use of my information for the purposes of treatment, payment, and healthcare operations. CHOVA reserves the right to modify the privacy practices outlined in the notice.

Signature: _____ **Witness:** _____ **Date:** _____
(Parent or legal guardian if client is under the age of 18.