NEWCare
New England Wound & Ostomy Care

HIPAA PRIVACY PRACTICES

I, _____, have been notified, read/received a written copy of
(Patient/Guardian Name Printed)

New England Wound Care, LLC's Notice of Privacy Polices on _____.
(Date)

I authorize New England Wound Care, LLC to discuss any health-related issues with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give permission for New England Wound Care, LLC and/or office staff to contact me in the following manner(s):

Personal Phone: ☐ Home Phone ☐ Cell Phone ☐ Answering Machine ☐ Family Member

☐ Leave message with detailed information ☐ leave message with call back number only

☐ Leave appointment information only

Work Phone: ☐ Ok to call work ☐ Leave message for call back number only ☐ Leave detailed message

Written Communication: ☐ Mail to home address ☐ Mail to alternate address listed below:

Alternate address: _____

Pharmacy: ☐ Ok to fax/call information to new and/or existing medication

Signature: _____ Date: _____
(Patient or Authorized Representative Signature)

This signature is good for 1 year unless otherwise revoked by you in writing.