(307) 682-7555
3100 West Lakeway Rd. Suite 1
Gillette, WY, 82718
highplains@vcn.com

HIPAA AGREEMENT FORM

High Plains Surgical Associates is committed to ensuring the privacy and confidentiality of your personal medical records. We comply with the national standard of the Health Insurance Portability and Accessibility Act of 1996 (HIPAA).

In order to assist us in protecting your privacy, please complete the following:

Patient Name: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone: ______________________________

Who may we speak with, other than yourself, regarding your medical care?
(If more than one, please list them all):

____

____

____

May we leave a message on your voice mail at home?	Yes ☐	No ☐
May we leave a message on your voice mail at work?	Yes ☐	No ☐
May we mail medical information to your home?	Yes ☐	No ☐

I have been made aware of the privacy policies of High Plains Surgical Associates, and have received (or a copy was made available to me), a copy of the Notice of Privacy Practices of High Plains Surgical Associates.

SIGNATURE ______________________________ **DATE** ____________________