GABEL CENTER

# HIPAA COMMUNICATION FORM

Patient Name:_____
First M.I. Last Name Used (if applicable)

Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

- ❑ **I give permission for Dr. Gabel and/or his staff to send mail to the above address.**
- ❑ **I do not give permission for Dr. Gabel and/or his staff to send mail to the above address.**

Preferred Pharmacy Name:_____

Address:_____

## I give permission for Dr. Gabel and/or his staff to contact me via:

- ❑ Home Phone:_____
- ❑ Cell Phone: _____
- ❑ E-mail Address: _____

## Who may we speak with at your telephone number(s)?

- ❑ May speak to anyone who answers the phone
- ❑ May speak with:_____ Relation: _____
- ❑ May not speak with anyone except myself

## Leaving a message on the phone:

- ❑ May leave any message
- ❑ May identify yourself and leave a number to return call

**Would you like to receive text messages or emails regarding new services, events, and special offers?**

- ❑ Yes
- ❑ No

_____ _____
Patient Signature Date