Privia Health
950 N Glebe Road, Suite 700
Arlington, VA 22203

MY PREFERRED CONTACTS

Patient Name: _____ Date of Birth: _____
Address: _____

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. We generally use our secure patient portal as our primary means of patient communication - such as to communicate test results - and **you** have the ability to control your portal access.

In some situations, however, it may be necessary and appropriate for us to share your information outside your portal. This may include information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. **Please update this information in writing promptly if your preferences change.**

Please indicate the person(s) with whom you prefer we share your information below. Note that we generally will not share your information via email; if you want, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact Patient Experience at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

- Full Name: _____ Telephone: _____
  Relationship: _____ Date of Birth: _____

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  Relationship: _____ Date of Birth: _____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons not named on this form as needed for my care or treatment or to obtain payment for services provided.

If I have provided e-mail addresses for my Preferred Contacts, my signature below indicates that I understand and acknowledge that e-mail communication is not secure. E-mail can be intercepted during transmission; and 2) unencrypted messages (and any attachments) can be read, and potentially copied and forwarded, by anyone.

Patient Signature: _____ Date _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)