

## PHI NOTIFICATION SHEET

MAY WE CONTACT THE PHONE NUMBERS YOU PROVIDED? YES NO

MAY WE IDENTIFY OURSELVES AS INTERNAL MEDICINE, DR. DRISS,  
OR MIKE SASSMANN'S OFFICE? YES NO

MAY WE LEAVE A MESSAGE ...?  
ON YOUR ANSWERING MACHINE? YES NO  
WITH A FAMILY MEMBER? YES NO  
WITH A SPOUSE OR SIGNIFICANT OTHER? YES NO

MAY WE SEND INFORMATION TO YOUR MAILING ADDRESS? YES NO  
IF NO, HOW WOULD YOU LIKE TO RECEIVE CORRESPONDENCE?

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MAY WE GIVE PERSONAL MEDICAL INFORMATION TO YOUR SPOUSE? YES NO

PLEASE LIST WHO MAY RECEIVE YOUR PERSONAL HEALTH INFORMATION.

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

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WE WILL NORMALLY SEND INFORMATION REGARDING YOUR CARE TO YOUR PRIMARY CARE PHYSICIAN OR A REFERRING PHYSICIAN.

DO YOU OBJECT TO RELEASING THIS INFORMATION TO THESE PHYSICIANS? YES NO

WE ARE REQUIRED TO RELEASE PERTINENT INFORMATION TO YOUR HEALTH INSURANCE CARRIER. IF THIS IS A PROBLEM, PLEASE NOTIFY THE OFFICE STAFF.

PLEASE NOTE THAT THE DEMOGRAPHIC, PHI, & SUMMIT RELEASE OF RECORDS FORMS WILL BE REQUIRED ANNUALLY.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_