Patient Contact & PHI Information Form

Patient's Name: ____ **Date of Birth:** ___________________

Phone Number:

1. ______________________________ Text? Y N Cell Work Home
2. ______________________________ Text? Y N Cell Work Home

Email:____

*@Gmail.com @Yahoo.com @Hotmail.com @Outlook.com @Aol.com @iCloud.com @*____________

Address:____

City, State, Zip:____

Gender: F M Other: ____

I authorize the following person(s) to receive Private Health Information (PHI) pertaining to my medical care other than myself or any Physician involved in my care:

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

Restriction of Private Health Information - Extremely Important Information:

If there is someone, such as a parent, that is restricted from receiving PHI information pertaining to a patient that is a minor, a HIPAA F Form must be filled out along with a copy of the legal documentation to support the restriction to the records. The HIPAA Form F and the legal documentation must be sent to our HIPAA Compliance Officer. If you need to complete this form, please have the manager assist you with this request.

If there is no restriction to access (see paragraph above), please initial: *______________

I acknowledge that I have read and/or received a copy of the Notice of Privacy Practices and Conditions of Service: **Yes** Initials: *_________

*____ *________________________________

Signature of Patient/Parent or Personal Representative Date Signed

*____ *________________________________

Print Name of Patient/Parent or Personal Representative Relationship to Patient