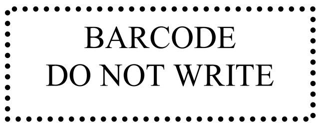
HIPAA Disclosure Form



PRINT PATIENT NAME: ________________________________

I. Please list the family members or the other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name____________________ Relationship__________________ DOB_____________

Name____________________ Relationship__________________ DOB_____________

Name____________________ Relationship__________________ DOB_____________

Name____________________ Relationship__________________ DOB_____________

II. Please list your primary care physician and any other physician's that you give us permission to release information to. This can include but is not limited to chart notes, op reports and diagnostic reports.

Physician__________________ Specialty _________________Phone #:_____________

Physician__________________ Specialty__________________Phone#:_____________

III. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home.

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IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": YES____________ NO _____________

V. Please print the alternative daytime telephone number(s) where you would like to receive communications regarding your appointments, lab and x-ray results, and other health care information: ( )_____________________ ( ) ______________________

*** I am fully aware that a cellular phone is not a secure and private line***

VI. Can confidential messages be left on your answering machine or voicemail?
YES_________ NO__________

VII. I am fully aware my health information will be transmitted by electronic transmission, fax transmittal, internet, or e-mail.

SIGNATURE: ____ DATE_________
(If Minor of 18 years Parent or Guardian)