DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please list below the names and contact information of individuals you authorize to receive your Personal Health Information (PHI).

Name: ________________________________
Relationship: ________________________________
Home Phone#: ________________________________
Cell Phone#: ________________________________

Name: ________________________________
Relationship: ________________________________
Home Phone#: ________________________________
Cell Phone#: ________________________________

Name: ________________________________
Relationship: ________________________________
Home Phone#: ________________________________
Cell Phone#: ________________________________

Name: ________________________________
Relationship: ________________________________
Home Phone#: ________________________________
Cell Phone#: ________________________________

For security purposes, please fill in one of the personal identifiers below so that we may verify whom we are speaking with before sharing your Personal Health Information (PHI).

Mother's Maiden Name: ______________________
Your City of Birth: ______________________
Your Favorite Color:______________________
Create your own identifier: ______________________

On occasion, we may need to call you and leave information regarding results of any treatments or tests that you have had.

May we leave this information on your voicemail? Yes No

May we leave appointment reminders on your voicemail? Yes No

If yes, please list your preferred contact number. Preferred Phone#: ________________________

Please list below the name(s) of the individual(s) that you would like us to contact in case of an emergency.

Name: ________________________________
Relationship: ________________________________
Home Phone#: ________________________________
Cell Phone#: ________________________________

Name: ________________________________
Relationship: ________________________________
Home Phone#: ________________________________
Cell Phone#: ________________________________

I, ________________________, do hereby acknowledge receipt of the Notice of Privacy Practices, Policies, and Procedures.

Patient Signature: ________________________________ Date: ______________

Parent/Guardian Signature: ________________________________ Date: ______________