COMPASSIONATE FAMILY MEDICINE
MEDICAL INFORMATION (HIPAA) RELEASE FORM

Patient Name: _____ **Date of Birth: _____/_____/_____**

Male [ ] Female [ ] Social Security #: _____ - _____ - _____

Address: _____
Street City/Town State Zip code

Home Phone: _____Cell Phone: _____Work Phone: _____Ext:_____

Email: _____ Language Preference: _____

Emergency Contact: _____ _____
Name / Relationship Phone Number

Insurance Carrier: _____ Policy Holder Name: _____

Policy Number: _____ Policy Holder: _____ Policy Holder SS#: _____ - _____ - _____

Pharmacy: _____ _____
Name/Address Phone Number

Release of Medical Information

NOTE: This *Release of Information* will remain in effect until terminated by the patient in writing.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse / Other: _____ Phone #:_____

[ ] Adult Child(ren): _____ Phone #: _____

[ ] Parent Name: _____ Phone #:_____

[ ] Other Name: _____ Phone #:_____

[ ] Information is not to be released to anyone.

Messages

Leave appointment message on:	**Yes**	**No**
Home Phone including automated service?		
Mobile Phone including automated service?		
Mobile Text including automated service?		
Work Phone?		
With another person? List name below.		
Send via Email / Portal?		
Send via Mail?		

Leave medical information on:	**Yes**	**No**
Home Phone including automated service?		
Mobile Phone including automated service?		
Mobile Text including automated?		
Work Phone?		
With another person? List name below.		
Send via Email / Portal?		
Send via Mail?		

I acknowledge that I have been given the opportunity to read and/or receive a copy of Compassionate Family Medicine's Notice of Privacy Practices.
[ ] Yes [ ] No

I consent to have the Practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my written authorization.

Signed: _____ Date: _____/_____/_____

I authorize the payment of medical benefits to above stated physician or supplier for services rendered.

Signed: _____ Date: _____/_____/_____