PAX MEDICAL ASSOCIATES, INC./Dr. Amanambu

1655 W. Market St. Ste. L Akron, Ohio 44313

Telephone (330) 375-0000 Fax (330) 375-0002

Patient Name:_____ DOB:_____

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Please circle I DO or DO NOT for each statement below:

I DO or DO NOT give Pax Medical Associates permission to call my home regarding information related to my care.

I DO or DO NOT give Pax Medical Associates permission to leave a message on my answering machine or voicemail regarding information related to my care.

I DO or DO NOT give Pax Medical Associates permission to mail information to my mailing address regarding information related to my care.

I DO or DO NOT give Pax Medical Associates permission to e-mail information to my e-mail regarding information related to my care.

I give Pax Medical Associates, permission to provide the following people with information regarding my medical care:

NAME	PHONE NUMBER	RELATIONSHIP

By signing below, I verify this information is correct to the best of my knowledge. I also verify that I have been given a Privacy Notice by staff of Pax Medical Associates.

Referral to Another Physician from Pax Medical Associates/Dr. Amanambu:

By signing below I also acknowledge that Pax Medical Associates/Dr. Amanambu will send and receive records to any physician which a referral is made. These records are limited to records that assist with continuity of care between the two offices.

_____ _____

Patient Signature/Date Staff Witness