Associated Medical Specialists, PA, d/b/a Coastal Cancer Center
Patient Annual HIPAA Update

Last _____ First _____ DOB: _____ Chart # _____

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HIPAA Contacts

HIPAA Contacts	Print Name	Relationship/Phone#	Please circle the information each person may receive
			CLINICAL APPOINTMENT FINANCIAL
			CLINICAL APPOINTMENT FINANCIAL
			CLINICAL APPOINTMENT FINANCIAL

May we leave messages? ☐ Yes ☐ No

If so, please circle each one signifying your consent CLINICAL APPOINTMENT FINANCIAL

Emergency Contacts/Who May We Notify?

Name _____ Relationship _____

Phone 1: ( ) _____ Phone 2: ( ) _____

Address _____ City/State/Zip + 4_____

Name of Relative NOT Living with You _____Relationship _____

Address _____ City/State/Zip + 4_____

Phone 1: ( ) _____ Phone 2: ( ) _____

_____ _____

Patient Signature Date

_____ _____

CCC Witness Date

☐ update HIPAA in IKM initials _____ scan in IKM 3/01/2018