Please PRINT all responses

PATIENT RECORD OF DISCLOURES

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Language if not English:**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Preferred Phone Number | **Secondary Number**

☐ O.K. to leave message with detailed information

If you would like to join our patient portal (web communication with our office including appointment requests, prescription refills, review test results) please leave your email address

Email Address

☐ O.K. to send an email

EMERGENCY CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Preferred Phone Number | **Secondary Number**

☐ O.K. to leave message with detailed information

☐ Leave message with call back number only

PHARMACY INFORMATION

Pharmacy | **Phone number:**

Address | **City** | **State** | **Zip Code**

In general, the HIPPA privacy rule gives individuals the right to request a restriction or uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, i.e. sending correspondence to an office instead of a residence.

Staff Use Only PATIENT'S MRN: _____