HIPAA AUTHORIZATION FORM

Please complete all information legibly.

Name: _____ Date of Birth: _____/_____/____

Release of Information

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

□ Spouse: _____

□ Child(ren): _____

□ Other: _____

□ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Appointment Reminders & Alerts

Appointment reminders can now be sent directly to you in the way that benefits you most. Please fill out the information below to help us in updating your preferences.

Home phone: _____

Cell phone: _____

Email address: _____

Please indicate which method you prefer as your primary means of receiving these alerts from our office:

□ Home phone – voice message

□ My cell – text message

□ Email

Other Messages

If you are unable to reach me:

□ You may leave a detailed message

□ Please only leave a message asking me to return your call

□ Other: _____

The best time to reach me is (day) _____

between (times) _____.

Consent to Treat

I authorize (onset guardian) to bring my child to Anchor Bay Clinic Family Medical Center to be seen by any physician in the office in my place that I cannot be present. I give permission to this guardian to make any necessary medical decisions if needed.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

_____ _____

Signature of Patient or Guardian Date