PATIENT INFORMATION, MEDICAL RECORD RELEASE, AND HIPAA AUTHORIZATION

Patient Name:_____
First Middle Last Suffix (Jr., III, etc)

Mailing Address:_____
Apt# City State Zip

Referred by:_____ Primary Care Provider:_____

RELEASE OF INFORMATION:

Please tell us how you wish to be contacted. Check all that apply.

Oral/Written Communication:

___ Home
(____) _____
____OK to leave message with detailed information
____Leave message with call back number/name only
____OK to mail correspondence to home

___Work
(___) _____
____OK to leave message with detailed information
____Leave message with call back number/name only

___ E-Mail address _____

Please tell us with whom we are allowed to discuss and/or disclose your Personal Health Information. Please note this does not include the release of Personal Health Information to entities as stated in Section A (Uses and Disclosures) of the Mitchell Dermatology's Notice of Privacy Practices.

Circle all that apply: Myself Spouse Adult Children Parents Sibling Personal Representative

Name(s) of above: _____ Phone: (___)_____

_____ Phone: (___)_____

My signature below authorizes the release of medical information to my primary care or referring physician and to process insurance claims/applications, prescriptions, and lab work.

In compliance with HIPAA regulations, we are required to have confirmation that you have been offered a written copy of Mitchell Dermatology's Notice of Privacy Practices. My signature below indicates that I have been given an opportunity to review a copy of Mitchell Dermatology's Notice of Privacy Practices.

If at any time you wish to change the information provided on this form, please ask for a new form prior to your appointment so your chart can be updated. Please do not hesitate to ask if you have any questions regarding the HIPPA regulations.

_____ ____/____/____
PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**

The patient information included on this form is true to the best of my knowledge. I herein authorize payment of medical benefits by my insurance carrier to the physician for services rendered when an assigned claim is filed. (TO FILE INSURANCE, YOUR SIGNATURE IS REQUIRED).

_____ ____/____/____
PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**