New Patient Demographics

Name:	DOB:	SS#:
Address:	City:	ST/ZIP:
Phone:	ALT Phone:	Email:
Employer:	Sex: M / F	Marital: M S D W
Referred: Yes or No	Referred By:	PCP:

Release of Information

Pertaining to the Health Insurance Portability and Accountability Act of 1996 (HIPPA), below is our attempt to protect our patients' right of privacy. Your signature indicates the degree to which your information is to be released.

Patient:	Age:	Phone Messages: Yes/No	Only Release to Patient: ( )

Name:	Name:	Name:
Relationship: ( )	Relationship: ( )	Relationship: ( )
Make and come to appointments: ( )	Make and come to appointments: ( )	Make and come to appointments: ( )
Diagnosis: ( )	Diagnosis: ( )	Diagnosis: ( )
Test Results: ( )	Test Results: ( )	Test Results: ( )
Treatment: ( )	Treatment: ( )	Treatment: ( )
Financial Info: ( )	Financial Info: ( )	Financial Info: ( )

Signature:	**Date:** / /

Records Release Authorization

I understand that by signing this authorization my healthcare information is authorized to be released to and from other healthcare facilities. I understand that health information may no longer be protected by the federal privacy standards and my health information might be re-disclosed without obtaining my authorization.

Requesting Doctor:	To (Hospital/Physician):
Information to be released	

Med. History: _____	Surgical Rep: _____	Patient Name:
Treatment/Test: _____	Hospital Rec: _____	DOB: / /
X-Ray Report: _____	Develop Dis: _____	Address:
Lab Reports: _____	Prescriptions: _____	City: State: Zip:
Consults: _____	Other:_____	Phone: ( ) - Fax:( ) - To:

Signature:	**Date:** / /