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/Cell
(___) _____H
(___) _____C

____ 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

____ Patient Portal

____ OK to leave message with detailed information
____ Leave message with call back number/name only

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 NorthWest Ohio Primary Care Physicians' Notice of Privacy Practices.

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

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

_____ (___) _____

My signature below authorizes the release of medical information to my primary care or referring physician 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 NorthWest Ohio Primary Care Physicians' Notices of Privacy Practices. My signature below indicates that I have been given an opportunity to review a copy of NorthWest Ohio Primary Care Physicians' Notice of Privacy Practices. I have also been offered information on Advance Directives/Durable POA.

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 HIPAA 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 to 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**