COMPLETE CARE PHYSICIANS

HIPAA AUTHORIZATION FORM – PATIENT INFORMATION UPDATE

Patient Name: _____ DOB: _____

Home: _____ Cell: _____ Work: _____

Email: _____

Address: _____

(Has it changed) __Yes or __No (if so, please complete new address below)

NEW ADDRESS: _____

Do we have permission to leave a message for you at home? Yes No

Do we have permission to leave a message for you at work? Yes No

I give permission to discuss my medical condition with the following:

Name/Relation: _____ Phone: _____

Name/Relation: _____ Phone: _____

Name/Relation: _____ Phone: _____

I give my permission to perform a prescription history search from external sources.

I have had the opportunity to review this office's "Notice of Privacy Practices forms," which explains how my medical information will be used and disclosed.

_____ Date: _____

Signature