Stellar Medical Group
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www.stellarmgaz.com

EMERGENCY CONTACT AND RELEASE OF PROTECTED HEALTH INFORMATION CONSENT

Patient Name: _____ Date of birth: ____ /_____/_____

Preferred Phone No.: _____ Cell Phone No.: _____

Please list BELOW the pharmacy you use including cross streets or phone number:

_____

List Email Address below for use with Stellar Medical Group's patient portal: https://health.healow.com/stellarmgaz

_____

☐ *I do not have an email* ☐ *I do not wish to share my email or access my records via portal*

We must call you at times to give you what is classified as protected health information. Please let us know how we can contact you with this information and if we can leave a message.

Can we leave detailed or confidential messages on your voicemail? **Yes** ☐ **No** ☐

Can we mail test results to your home? **Yes** ☐ **No** ☐

Can we send you text reminders ? **Yes** ☐ **No** ☐

Can we lookup/import your prescription history electronically from your pharmacy? Yes ☐ No ☐

Exclusions/Alerts (Please note any information that you do not want released to authorized individuals:

_____

Emergency Contact: _____Relationship to Patient: _____

Home Phone:_____ Cell Phone: _____

BESIDES THE PERSON LISTED AS MY EMERGENCY CONTACT, I AUTHORIZE THE FOLLOWING ADDITIONAL PEOPLE WHO MAY RECEIVE MY PROTECTED HEALTH INFORMATION**. I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVING WRITTEN NOTIFICATION TO THIS OFFICE.**

Name	Relationship	Phone

Patient Signature: _____ Date: ___/____/_____