



Hometown Direct Primary Care

332 N. Bright Leaf Blvd, Suite C
Smithfield, NC 27577
Phone (919) 901-7344 Fax (319) 250-7453

HIPAA Disclosure Form

Patient Name: _____ DOB: _____

Address: _____

City/State: _____ Zip: _____ Email: _____

Home phone: _____ Cell: _____ Work: _____

Preferred contact number? Home Cell Work

May we identify ourselves over the phone? Yes No May we leave messages? Yes No

I, _____, hereby authorize Hometown Direct Primary Care to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, minor procedures, etc) via postal mail, telephone, fax or email to the following family members/individuals:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

I further release my medical information to the following physicians/clinics:

Physician: _____ Clinic: _____ Phone: _____

Physician: _____ Clinic: _____ Phone: _____

Physician: _____ Clinic: _____ Phone: _____

Physician: _____ Clinic: _____ Phone: _____

Physician: _____ Clinic: _____ Phone: _____

Physician: _____ Clinic: _____ Phone: _____

Signature: _____ Date: _____