Hometown Direct Primary Care

332 N. Bright Leaf Blvd, Suite C
P.O. Box 2559
Smithfield, NC 27577
Phone (919) 901-7344 Fax (319) 250-7453

HIPAA Disclosure Form

Patient Name: _____ SSN: _____

Address: _____ DOB: _____

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:_____

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: _____