Crescent Beach
• C A R E •

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle Name:

Date of Birth:	Social Security Number:	Marital Status:	Age:	Sex: F M

Address:

City: State: Zip:

Would you like secure online access to your health record? Yes No	If yes, please provide your email address:	Preferred Pharmacy:

Race:	Ethnicity: Non-Hispanic Hispanic Not Specified	Language:	Pharmacy Phone #:

Home phone:	Cell phone:	Occupation:

Insurance:	Policy Number:	Employer:

Chose clinic because:	Referred by:

IN CASE OF EMERGENCY

Name:	Relationship:	Phone:	Address:

Medical Information Release Form (HIPAA Release)

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____

Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

I have read and understand the following policies and agree to abide by their guidelines:

- **The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Crescent Beach Care, LLC or insurance company to release any information required to process my claims.**
- **Release of Information**
- **Payment Policy**
- **Notice of Privacy Practices**

_____ _____

Signature of patient or responsible party **Date**

_____

Printed name