PATIENT REGISTRATION - PLEASE PRINT

NAME _____ _____ BIRTHDATE _____ SEX _____
(Last) (First) (MI) MARITAL STATUS [] M [] S [] [] D [] W

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____

Mailing/ Winter
Address_____

EMAIL_____ _____ PREFERRED LANGUAGE _____ RACE _____

WORK PHONE _____ CELL PHONE _____

EMERGENCY CONTACT _____Relationship to Patient_____ PHONE_____

DUAL CONSENT FORM

The physicians and staff of Lakeside Internal Medicine dedicated to providing excellent healthcare. We are committed to protecting every patient's right to privacy.

The purpose of this form is to provide you with a way of letting us know of other people you want to have access to your health information. Sometimes this person is a spouse, may be a son or daughter, or even a friend that helps you make or keep appointments. There are many reasons why you might want to give others access to your health information. You might have someone pick up a referral, written prescription or medication samples for you. You might have a vision or hearing loss that requires someone's assistance with telephone messages or written material. You might prefer someone else take care of the insurance issues. **No matter what the reason is, we are required to have your permission to allow predetermined people gain access to your protected health information.**

Please complete the following:
I give the physicians and staff of Lakeside Internal Medicine permission to discuss or share my protected health information with: If you do not want anyone, you must write NONE

Name: _____ Relationship to patient: _____PH#_____

Name: _____ Relationship to patient: _____PH#_____

Name: _____ Relationship to patient: _____PH#_____

Patient Signature: _____ Date: _____

****This consent will remain in effect until revoked in writing by the patient. ****