ALLERGY & ASTHMA CARE OF INDIANA
PATIENT REGISTRATION

Date _____

Name: _____ Preferred Name_____
Last First Middle

Date of Birth: _____ Gender: M/F Marital Status: Single/Married/Other

Address: _____ City/State/Zip: _____

Primary Phone #*: _____ (home/cell) Cell Phone #: _____

*Appointment Reminders are made to Primary Phone #. SS# _____ Email: _____

If patient is a minor: Mother's Name _____ #_____
Father's Name _____ #_____

Employer _____

Address_____ City/St/Zip _____Work Phone# _____

PRIMARY INSURED PARTY INFORMATION

Name _____ Male Female DOB_____
Last First Middle

SS# _____Relationship to Patient _____ Home Phone# ( )_____

Address _____City _____State_____ Zip_____

Employer_____Address_____

City_____ State_____ Zip_____ Work Phone# ( ) _____

SECONDARY INSURED PARTY INFORMATION

Name _____ Male Female DOB_____
Last First Middle

SS# _____Relationship to Patient _____ Home Phone# ( )_____

Address _____City _____State_____ Zip_____

Employer_____Address_____

City_____ State_____ Zip_____ Work Phone# ( ) _____

EMERGENCY CONTACT

Name Relationship Preferred Phone#

PRIMARY CARE PHYSICIAN - Mark box if no PCP ☐

Name Address Phone#

REFERRING PHYSICIAN

Name Address Phone#

_____ _____
Patient Signature (Parent/Guardian) **Date**

ALLERGY & ASTHMA CARE OF INDIANA
CARMEL • INDIANAPOLIS • GREENFIELD
BOARD CERTIFIED IN ALLERGY & IMMUNOLOGY
Treating patients of all ages
GARRICK P. HUBBARD, M.D. JOEL C. SHOUSE, FNP-C

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated.

Patient Name: _____

Date of Birth: _____

Entity Requested to Release Information: **Allergy & Asthma Care of Indiana**

Who will be authorized to receive information - I authorize the entity identified above to disclose or provide protected health information about me to the individual/entity listed below:

Individual/Entity Name: _____ Individual/Entity Name: _____

Phone/Fax: _____ Phone/Fax: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only disclose the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.