PATIENT CONTACT INFORMATION FORM

NAME: _____ DOB: _____

What would you like us to call you? _____

ADDRESS: _____

_____

PHONE NUMBERS – Please list in order of preference and identify as cell/home/work – e.g. C, H, W

1)_____ 2)_____ 3)_____

E-mail Address: _____

DESIGNATED INDIVIDUALS AUTHORIZED TO SHARE YOUR PROTECTED HEALTH INFORMATION

Please designate your emergency contact person with an asterisk*

Name:	Contact Phone Number:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPECIAL REQUESTS OR CONSIDERATIONS

_____

_____

Patient Consent for Use & Disclosure of Protected Health Information

By the signature below, I acknowledge that I have received the Notice of Privacy Policies (HIPPA Form). I consent that Dr. Cheryl Kinney and her staff may contact me or my designated patient representative at the above-listed mailing address, email address or telephone numbers regarding my medical care, test results and other clinical issues. This contact information may also be used for appointment reminders, billing and other administrative purposes. In addition, unless otherwise noted, messages may be left for me or my designated representative at these same contact addresses and phone numbers.

PRINTED PATIENT NAME	**SIGNATURE OF PATIENT/LEGAL GUARDIAN**	**DATE**
_____	_____	_____