

HIPAA Patient Contact Form



Perry Medical Clinic, P.C.
Your Healthcare, Our First Priority.

Patient Name: _____ **Date of Birth:** _____

Social Security Number: _____

Any physician, staff, employee or representative of Perry Medical Clinic, PC has my permission to **discuss** my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Perry Medical Clinic, PC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature: _____

Date: _____