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Diplomates of the American Boards of Internal Medicine and Cardiovascular Disease

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(805) 485-3800

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PLEASE PRINT

Patient's Name	**Social Security No.**	**Date of Birth**		**Sex M F**
Street Address	**City, State & Zip**		**Cell Phone:**	**( )**
			Home Phone:	**( )**
Patient's Employer	**Occupation**		**Work Phone:**	**( )**
			Ext.	**( )**
Employer Street Address	**City, State & Zip**			
Spouse's or Parent's Name	**Social Security No.**	**Date of Birth**	**Cell Phone:**	**( )**
			Home Phone:	**( )**
Spouse's or Parent's Employer	**Occupation**		**Work Phone:**	**( )**
			Ext:	**( )**
Emergency Contact	**Relationship**		**Cell Phone:**	**( )**
			Home Phone:	**( )**

REFERRING PHYSICIAN:: **PRIMARY CARE PHYSICIAN:**

DISCLOSURE OF INFORMATION

HIPAA gives individuals the right to restrict the use and disclosure of their protected health information (PHI). Individuals may request confidential communications of PHI to alternative locations such as the individual's office instead of the individual's home. HIPAA generally requires healthcare providers to take reasonable steps to limit the use and disclosure of PHI to the minimum necessary to accomplish the intended purpose. Those provisions do not apply to uses and disclosures made pursuant to signed authorization by the individual. Healthcare entities must keep records of PHI disclosures. Uses and disclosures of PHI may be permitted without prior consent in an emergency.

I request to be contacted in the following manner (check all that apply and circle first choice)

Cell Phone	**Home Phone**	**Work Phone**	**By Mail**
☐ **Message with detailed information**	☐ **Message with detailed information**	☐ **Message with detailed information**	☐ **Home address**
☐ **Message with call-back number only**	☐ **Message with call-back number only**	☐ **Message with call-back number only**	☐ **Work address**
		☐ **Fax:** _____	

Patient's Signature **Print Name** **Date**

I authorize release of any medical information to:

Name **Relationship**

Name **Relationship**

PRIMARY MEDICAL INSURANCE	***SECONDARY MEDICAL INSURANCE***
Insurance Co	**Insurance Co**
Group #	**Group #**
Subscriber ID #	**Subscriber ID #**
Insurance Co. Phone #	**Insurance Co. Phone #**
Name of Policyholder	**Name of Policyholder**
Relationship to Patient	**Relationship to Patient**
Policyholder's Birthdate	**Policyholder's Birthdate**
Policyholder's Soc. Sec.	**Policyholder's Soc. Sec.**
Policyholder's Employer	**Policyholder's Employer**

10/2010

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