

Caring Family Health Nurse Practitioners PLLC
 6846 Buckley Road Suite 2
 North Syracuse, New York 13212
 Phone: 315-980-9892 Fax: 315-282-2344
 www.Caringfamilyh.com

MEDICAL INFORMATION (HIPAA) RELEASE FORM

Patient Name <i>(first, middle, last)</i>		Date of Birth <i>(mm/dd/yyyy)</i>	Social Security Number
Email Address		Preferred Language	Gender [] F [] M [] Other
Address			
Home Phone	Cell Phone	Work Phone	
Emergency Contact <i>(Name / Relationship)</i>			Phone Number
Insurance Carrier		Policy Holder Name	
Policy Number		Policy Holder SSN	
Pharmacy <i>(Name / Address)</i>		Pharmacy Phone Number	

Release of Medical Information

Note: This Release of Information will remain in effect until terminated by the patient in writing.

[] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name..... Phone number.....

[] Information is **not** to be released to anyone.

Can we leave a voice mail with medical and appointment in above phone number: Yes No

I acknowledge that I have been given the opportunity to read and/or receive a copy Caring Family Health Nurse Practitioners PLLC Notice of Privacy Practices: Yes No

I acknowledge that I have been given the opportunity to read and/or receive a copy of Caring Family Health Nurse Practitioners PLLC Policy and Procedure. Yes NO

I consent to have the Practice use and disclose my protected health information for payment, treatment, and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my written authorization.

Signed: _____ **Date:** ____/____/____

I authorize the payment of medical benefits to above stated providers practice or supplier for services rendered.

Signed: _____ **Date:** ____/____/____

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