How did you hear about us?: _____

Patient: _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____ **SS #:** _____

Address: _____ _____ _____
(City/State) (Zip Code)

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
May we leave a message? Y N May we leave a message? Y N May we leave a message? Y N

E-mail address: _____ **Gender: M F** **Marital Status: M W D S**

Employment status: FT PT Unemployed

Race (please circle): American Indian/Alaskan Native Black or African American Other Race Decline to report
Asian White Hispanic

Ethnicity: Hispanic Non-Hispanic Decline to report

Patient Authorization for the Disclosure and Usage of Protected Health Information (P.H.I.)
Acknowledgement of Notice of Privacy Practices

I, _____, understand that Healing Grace Clinic is authorized by me to use or disclose my protected health information for a purpose not other than, payment or health care operations. I have read the "Notice of Privacy Practices" overview and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.

I specifically authorize any current employee or volunteer of Healing Grace Clinic, or any other individual listed below to disclose my protected health information. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

I further understand that I retain the right to revoke this authorization through a signed and updated copy of another P.H.I. Permission Authorization.

Contact Information:

We may speak to or leave messages with the following people about your medical care/test results. ***Please list emergency contact first***:

Name Phone Relationship

_____ - **Emergency Contact**

_____

_____

_____

By signing this form, I agree that the above information is true and accurate to the best of my knowledge. I also agree to the authorization as stated above.

_____ _____
Signature Date

Pharmacy Name: _____ **Pharmacy Phone:** _____
