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Complete Care Medicine

Privacy Practice Acknowledgement and Family Auth

Patient Information (Please Print):

Name:_____ Date of Birth: _____

Phone:_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under HIPAA requirements, we are not allowed to release this information without the patient's consent. If you would like us to release billing or medical information to family members you must sign this form. Only the family members listed below **CAN** have access to your records.

1._____ Relationship to Patient: _____

2._____ Relationship to Patient: _____

3._____ Relationship to Patient: _____

Please list any family members that you **DO NOT** want CCM to discuss your medical or billing information with:

1._____

2._____

Complete Care Medicine is authorized to: (Please check appropriate boxes below.)

- ☐ Call my home phone number
- ☐ Call my cell phone number
- ☐ Call my work phone number
- ☐ Leave a message on my home phone number
- ☐ Leave a message on my cell phone number
- ☐ Leave a message on my work phone number

By voluntarily signing this form I affirm that I am the above patient, parent or legal guardian and have read and fully understand all statements made in the Notice of Privacy Practices. I am aware that I may request a copy of the Notice of Privacy Practices for Complete Care Medicine and one will be provided to me. I understand that I have the right to revoke this authorization at any time by providing a written statement to Complete Care Medicine where the authorization was originally submitted, except to the extent that CCM has already completed action on it. I understand that when this 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. **I understand that this authorization will remain in effect indefinitely unless revoked in writing by the patient or legal representative.**

Patient's Signature _____ Date _____

Parent/Legal Representative Signature/Relationship To Pt _____ Date _____