

HEALTHFIRST HERITAGE TRACE

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually.

Date: _____

I, _____, authorize **HealthFirst Heritage Trace** to release my medical or insurance information as necessary to process my medical claims and coordinate or manage my healthcare.

In the event a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation and/or treatment, I give **HealthFirst Heritage Trace** and its physicians, or employees my permission to discuss freely my condition, treatment, or diagnosis with that person.

Home Phone: _____

Work Phone: _____

Cell Phone: _____

May we leave a message at one of the numbers listed above about appointments and test results?

Yes/No

Home/Work/Cell

All of the above

With whom may we discuss or release information about your care, treatment or diagnosis?

_____ Relationship _____ Phone#() _____

_____ Relationship _____ Phone#() _____

Signature: _____

(Signature is valid one year from date shown above)

Print Name: _____