SPECTRUM
HEALTH CARE

HIPAA Disclosure Form

Preferred Name and Pronoun ____ Date of Birth: ___/___/___

Legal name (Required to create Medical record) ____

What is the preferred address for correspondence? ____

____

Would you like our correspondence with you to be marked "Confidential"? ___ Yes ___ No

May we identify ourselves over the phone? ___ Yes ___ No

May we leave messages? ___ Yes ___ No

Emergency Contact Name ____________________________________ Relationship __________________

Phone number ____

I, the Patient, hereby authorize Spectrum Health Care provider/staff to release my medical information (appointments, lab/x-ray results, diagnosis, treatments, medications, surgeries, etc.) to the following person (s):

Name ____________________________________ DOB ___________ Relationship _______________

Name ____________________________________ DOB ___________ Relationship _______________

Name ____________________________________ DOB ___________ Relationship _______________

Name ____________________________________ DOB ___________ Relationship _______________

Name ____________________________________ DOB ___________ Relationship _______________

Name ____________________________________ DOB ___________ Relationship _______________

I further release my medical information to the following physician / clinic:

Doctor/Clinic ____ Phone ________________________

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Doctor/Clinic ____ Phone ________________________

I understand I can add or remove the person(s) at any time. It is my responsibility to inform the staff at Spectrum Health Care of any changes I wish to make.

Signature ____ Date _________________