Ardmore Family Practice, P.A.

PHONE: 336-659-0076
FAX: 336-659-0272

PROTECTED HEALTH INFORMATION DESIGNATION FORM

Patient Name: _____ MR #_____

Date of Birth:_____

You may give Ardmore Family Practice written authorization to disclose your protected health information (PHI) to anyone you designate and for any purpose.

Please complete the questions below. Only provide information which you consider acceptable as a means of contacting you and your designated contacts. Please see Notice of Privacy Practices for details.

You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will no longer disclose PHI.

My Home Number:_____ OK to leave message on voice mail? Yes / No

My Work Number:_____ OK to leave message on voice mail? Yes / No

My Cell Number:_____ OK to leave message on voice mail? Yes / No

My Email:_____ OK to send email? Yes / No

At my request, I authorize Ardmore Family Practice to disclose my PHI to:
You may leave this blank if you do not wish any disclosures be made.

Name:_____ Home #_____Work#_____

Cell #_____Relationship to patient_____

Name:_____Home #_____Work #_____

Cell #_____Relationship to patient_____

Specific check information to be disclosed.

____ Medical Records ____ Labs

____ X-rays/Diagnostic ____ Insurance & Billing Information

Signature_____Date_____