STONE MOUNTAIN FAMILY PRACTICE

As your provider, we are committed to maintaining the privacy of your healthcare information, as well as communicating with you in the most effective manner. Please take a moment to complete this form to ensure that we can contact you.

I authorize Stone Mountain Family Practice to contact me regarding my medical information by means of the listed methods. I will also be responsible for contacting the office should this information change.

Home telephone #:____________________________

May we leave messages on your home answering machine? Yes No

Work telephone#:_____________________________

May we leave messages on your work voice mail? Yes No

Cell phone #:_________________________________

May we leave messages on your cell phone voice mail? Yes No

The providers/staff may use or disclose the following health information only to the following list of people:

- All test results Yes No
- The entire medical record Yes No
- Most recent visit Yes No
- Financial information Yes No
- Pick up prescriptions on my behalf Yes No

Spouse: Yes No Name:____

Parent(s): Yes No Name(s):____

Children: Yes No Name(s):____

Other: Please give name and relationship (aunt, uncle, cousin, friend, etc)

Name:____

____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY THE PATIENT.

Patient Name (printed)____ Date of Birth:_______________________

Patient/parent/guardian signature: ____

Date signed:_____________________