THE CHRIST HOSPITAL PHYSICIANS
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Today's Date: _____

R 7 2 3 0 B

Patient's Legal Name: _____ _____
Last First Middle Initial Date of Birth

Contacts: In the event you are incapacitated, there is an emergency, or if we are unable to reach you, are we permitted to discuss or release your health information* to the following identified individual(s)?:

☐ Yes (Complete information below) ☐ No (Skip to the next question)

Name: _____ Name: _____

Relationship to Pt: _____ Relationship to Pt: _____

Home #: (____) _____ Home #: (____) _____

Work #: (____) _____ Work #: (____) _____

Cell #: (____) _____ Cell #: (____) _____

*health information includes, but is not limited to: test results, prescription refills, billing questions and if needed, cases of emergency.

May we leave messages/test results on your answer machine? Y N

May we call you at your place of employment? Y N

If printed prescriptions or sample medications are needed, the following may pick up prescriptions and/or sample medications:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care at TCHP. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

❑ I received a copy of the Notice of Privacy Practices.

❑ I have previously received a copy of the Notice of Privacy Practices.

❑ I do not want a copy of the Notice of Privacy Practices.

_____ _____
SIGNATURE OF PATIENT (if 18 years or older) OR LEGAL GUARDIAN IF APPLICABLE Date/Time