Authentic HEALTH
FAMILY CARE + PRECISION MEDICINE

Patient Name:_____ **DOB:**_____

HIPAA CONTACT INFORMATION:
In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and employer.

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, billing, appointments, or administrative operations related to treatment and payment. I understand that the identities of each designated party must be verified before the release of any information.

My Rights: I understand that I do not have to sign this authorization form in order to receive health care treatment. I may revoke this authorization by writing a letter to Vickery Family Medicine, PLLC. I realize that revocation will not affect any actions already taken based upon this authorization and that revocation may not be possible if the purpose of authorization was to obtain insurance. Once protected health information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Phone # where we may leave clinical/admin/treatment messages: _____

Please provide the name(s) and phone number(s) with whom we may leave the following (indicate yes or no):

Name & Relationship to Patient	Phone Number	Leave Messages: Appointments	Leave Messages: Treatments	Speak To: Appointments	Speak to: Treatments

You must inform us **in writing of any changes in your directives.

To be completed annually, at the time of first visit or when renewing HIPAA notice:

I certify that I have been given the opportunity to review my patient information, such as my address, phone number, and emergency contact person, and that all demographic information in my electronic health record is true and current. I also certify that the above listed individuals may be contacted regarding my care as I have specified.

Patient signature:_____ Date:_____