

PATIENTS 18 AND OLDER MUST COMPLETE AND SIGN THIS FORM THEMSELVES.

Patient Name _____ DOB _____ Age _____

Email Address: ___ Yes ___ No _____

Race: ___ American Indian or Alaska Native ___ White ___ Hispanic ___ Black or African American
___ Asian ___ Native Hawaiian or Other Pacific Islander ___ Other ___ Unreported/Refused to Report

Preferred Language: ___ English ___ Spanish ___ Indian (Hindi & Tamil) ___ Russian ___ Other

Ethnicity: ___ Hispanic or Latin ___ Not Hispanic or Latin ___ Refused to Report **Gender:** ___ M ___ F

Please indicate below those you authorize to receive your protected health information.

1. _____
Name Phone Number Relationship
2. _____
Name Phone Number Relationship
3. _____
Name Phone Number Relationship

I authorize these people to have access to my medical information. _____ pt. initials

Please understand this information will only be given to those you have indicated here.

I request the following restriction(s) concerning the use of my personal medical information: _____

Emergency Contact: _____

Name	Relationship	Phone Number	Date
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I authorize the above named person to be my emergency contact. In the event of a medical emergency situation, this person may receive my PHI (Protected Health Information) related to the emergency for which they were contacted. This person may or may not be on my Authorized Representative List to receive my PHI; therefore, they may or may not have access to any other medical information except the emergency. Pt initials _____

Do you have an advance directive such as a living will or durable power of attorney for your healthcare in the case you are unable to make your own medical decisions? ___ Yes ___ No **If yes, please provide copy.**

May we leave appointment, x-ray and/or laboratory information on your answering machine? ___ Yes ___ No

May we leave appointment, x-ray and/or laboratory information on your cell phone voicemail? ___ Yes ___ No

May we contact you at work? ___ Yes ___ No

I have been offered or given a **Notice of Privacy Policies** from the office of Middle TN Family Medicine detailing how my Protected Health Information may be used and disclosed as permitted under federal and state law. _____ pt initials **(Copies of the privacy notice are available at the front desk. Please feel free to take one.)**

I hereby authorize you to release and/or request any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners, including test results which may include drug and/or alcohol, psychological conditions or Acquired Immunodeficiency Syndrome. I authorize and request my insurance company to pay insurance benefits otherwise payable to me directly to the physician. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

* Due to our office policy, we do not file tertiary insurance.

Signature of patient (or parent if minor) Date

If not signed by patient, please indicate relationship to patient. _____

MEDICARE PATIENTS AUTHORIZATION I request that payment of authorized Medicare benefits be made to Middle TN Family Medicine on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration any information needed to determine benefits payable.

Signature: _____ Date: _____