18+ Patient Registration

Last Name: _____ First Name: _____

Middle Initial: _____ Date of Birth: _____

Ethnicity: Unknown / Hispanic or Latino / Not Hispanic or Latino / Decline to specify

Race: American Indian or Alaskan Native / Asian / Black or African-American / Native Hawaiian or Other Pacific Islander / White / Decline to specify / Other Race

Street Address: _____

City: _____ State: _____ ZIP code: _____

Primary phone number: _____

Email Address: _____

Preferred method of contact (please circle **one**):

Recall notices: Text message / Phone call / Email / No contact

General practice notices: Text message / Phone call / Email / No contact

Portal notices: Portal notices will be sent via email

Appointment reminders: Text message / Phone call / Email / No contact

Emergency contacts (name and relationship):

1. _____ Phone: _____

2. _____ Phone: _____

*Insurance: Please be sure to give a copy of your card to staff so we have correct billing information.

NOTICE: If you would like to share your medical health information with a third party, such as a parent, you will need to complete the backside of this form. Thank you.

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated each year.

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information:

Alger Pediatrics, P.C.

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI)**:**

Individual/Entity Name: _____

Address: _____

Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report (previous 3 years only)
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire one year from the date of your most recent signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than one year from the date of your most recent signature: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

patient or representative signature date

_____ _____

patient or representative signature date

_____ _____

patient or representative signature date

_____ _____

patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.