PATIENT INFORMATION SHEET & WAIVER

Patient Name________________________________ MI _____ Today's Date: _____________________

Address____

Social Security #_____________________ Driver's License #___________________________

Home Phone #_________________ Cell#__________________ Work#___________________

Date of Birth__________________ Age______ Sex______ Marital Status_______

Employer_____________________________Occupation_____________________Student_____

Employer's Address____

Spouse/Guarantor's Name______________________________________

Date of Birth_______________ Social Security #______________________________

Spouse's Address_______________________________________ Phone #________________

Spouse's Employer_______________________________________ Phone #________________

Emergency Contact____

Relationship______________________________ Phone #________________

Email_______________________________________ **can we contact you via email_________**

Previous Primary Care Physician____

Pharmacy Name__________________________ Phone #_________________________

Have you ever been seen by SFP under a different name?_____ What name_______

I, ________________________________(Patient Name), authorize SOUTHLAKE FAMILY PRACTICE to use and disclose certain protected health information (PHI) currently maintained by SFP subject to the following specifications:

- **The PHI to be used or disclosed is limited to the following data elements: Entire medical chart, including current and past medical history including patient demographic and billing information.**
- **The names or other specific identification of the person(s) or class(es) of persons, authorized to make the requested use or disclosure of the data specified above, are: the entire SOUTHLAKE FAMILY PRACTICE staff.**
- **The names of the person(s) to whom SFP may provide the requested use of disclosure specified above are:**

____ ____

____ ____

This authorization expires when so determined by the individual patient and I recognize that the protected health information (PHI) used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected.
I also hereby authorize payment directly to SOUTHLAKE FAMILY PRACTICE. I understand that I am financially responsible for charges not covered by this assignment. I authorize the release of information necessary to process insurance claims and coordinate my medical care.

Acknowledged and agreed to by (Patient Signature)____

Patient Name (printed)___________________________________Date of signing_____________________