AMHERST MEDICAL ASSOCIATES
HIPAA & EMERGENCY CONTACT INFORMATION

Patient Authorization for Use and Disclosure of Protected Health Information (PHI) from the Practice

By signing this form, I authorize Amherst Medical Associates, LLP to use and/or disclose certain PHI about me to the contact listed.

_____

(Name, Relationship, and Telephone number of HIPAA appointed contact)

- I would like the above named person to pick up medical items, including prescriptions, from the office if I am unable to:

  Yes_____ No_____

- This authorization will expire: upon death _____ or specify date: _____

- This authorization permits the practice to use and/or disclose the following identifiable health information about me:

  All medical care needs_____ Other_____

If other, specifically describe the information to be used or disclosed; such as date(s) of service, level of detail to be released or origin of information:

_____

_____

Our Office may contact you with appointment and medical information through home#, cell#, work#, Text, Email, Patient Portal, or with your HIPAA appointed person unless otherwise specified below:

_____

Emergency Contact Information

(If contact is the same as above, please indicate by writing "Same as above" and include address and D.O.B)

(1)Name_____
Please Print name DOB Relationship

Address_____
Street City State Zip

Phone number (Home#) _____ (Cell#) _____ (Work#) _____

(2)Name_____
Please Print Name DOB Relationship

Address_____
Street City State Zip

Phone number (Home#) _____ (Cell#) _____ (Work#) _____

Patient name (print) _____D.O.B_____

Patient Signature_____Today's Date_____