CAPITAL INSTITUTE FOR NEUROSCIENCES
HIPAA CONSENT TO RELEASE MEDICAL INFORMATION
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Patient Name: _____ Date: _____

DOB: _____

I. When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., please indicate where we can leave a message:

CIRCLE YES OR NO

HOME NUMBER ~ YES / NO _____

CELL NUMBER ~ YES / NO _____

II. MY PRIMARY CARE PHYSICIAN INFORMATION
Name: _____

Address: _____

Phone: _____

III. I AUTHORIZE THE FOLLOWING INDIVIDUALS TO RECEIVE INFORMATION PERTAINING TO MY MEDICAL CARE.

NAME	RELATIONSHIP	CONTACT NUMBERS

I agree _____ to the above. Date Signed: _____
(Patient Signature)

Signing this form verifies all information is correct and/or has been updated.

Please update form at each visit
Signature _____ Date _____
Signature _____ Date _____
Signature _____ Date _____
Signature _____ Date _____
Signature _____ Date _____