Family Health Care Center P.C.

23702 Hwy 80 East Statesboro, GA 30461

Ph. # 912-489-4090

HIPAA FORM

PATIENT NAME:_____DATE OF BIRTH:_____

1. Please list any family member or other persons / physicians to whom Family Health Care Center may release information concerning your medical records:

   NAME_____PH#_____RELATIONSHIP_____

   NAME_____PH#_____RELATIONSHIP_____

   NAME_____PH#_____RELATIONSHIP_____

   Please Note: Our automated computer system will automatically call all patients with appointments 2 days prior to the scheduled appointment date. Please confirm YES with the system by pressing #1 or cancel the appointment by pressing #2.

   Please list the best number for all appointment reminder calls :_____

2. May Family Health Care Center leave messages on your home answering machine or voicemail? Please Circle : YES or NO
3. Please indicate if you would like to create a patient portal account. With this account, you will be able to review your lab results, ask non-urgent medical questions, request medication, and schedule appointments.

   Would you like to enroll? Please Circle: YES NO Already Enrolled

4. If permissible, please provide an email address to create a patient portal account.
   EMAIL:_____

This will remain in effect until I give written notification to discontinue.

Patient or Guardian Signature:_____DATE:_____

Parent/Guardian of minors under age 18 has access to medical records, with the exception of any State Law protecting the privacy of information of minors.