MESQUITE EMPLOYEE HEALTH CENTER

Authorization of use and Declaration of Protected Health Information

Patient's Name:_____ Age:_____

Patient's Home address:_____City_____Zip_____

Home phone: _____ Cell phone: _____

Patient's Social Security #:_____ Date of Birth:_____ Patient: -Select-

Insured's : -Select- Dept /School Employed at _____Work phone_____

Insured's Job Title: _____Patient's relationship to Insured_____

If you have an answering machine or EMAIL address, may we leave messages regarding appointments, treatments and or/other information pertinent to your healthcare? -Select-

Please let us know the BEST way to contact you? Check one or more: ☐Home ☐Cell ☐Work ☐Email

If you would like us to give detailed lab results on your secure email address please provide your email below: Please print clearly to insure you receive it. If you do not have email please leave blank.

EMAIL address: _____ **MUST BE SECURED EMAIL**

May we speak to you spouse or parents: -Select- Name of Spouse or Parents:_____

If you are filling this out for your child's appointment today, we need to know who may bring your child to their appointments when you are unavailable:_____

In case of an Emergency Please provide a contact person, if patient is a MINOR we would like someone other than parents because we would automatically contact parents:

Name:_____ Phone:_____

Relationship to Patient:_____

_____ _____ _____

SIGNATURE OF PATIENT OR Authorized Person Relationship to patient Todays Date