Patient Registration/HIPAA Authorization

Patient Name: _____

Date of Birth: _____

Social Security Number(optional): _____

Address: _____

_____

Primary Phone: _____ **Alternate Phone:** _____

Email Address: _____

Emergency Contact: _____ _____
Name **Relationship to patient**

Phone Number: _____

Preferred Pharmacy (Local): _____

Mail Order Pharmacy (If applicable): _____

Who are we allowed to share information with about your care (HIPAA)? (*I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).*

_____	_____	_____
Name	**Phone Number**	**Relationship**
_____	_____	_____
Name	**Phone Number**	**Relationship**

If patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization

Print Name (*Patient/Authorized Representative*) _____

_____ _____
Signature **Date**

By signing this form, I am giving my consent for treatment to Landmark MD and acknowledging that I have received a Notice of Privacy Practices for my review