DR. ROXANNE EDRINGTON, D.C.,CCN

425 E NASA PARKWAY

WEBSTER, TX 77598

PATIENT INFORMATION SHEET

Name:

_____

Address:_____ D.O.B._____

City:_____St:_____Zip:_____

Phone: Home_____ Cell_____Work_____

Email:_____

Emergency Contact:_____

Insurance Company:_____Insured Name:_____

Insured Date of Birth:_____

Member ID#_____Group#_____

Employer Name:_____

Drug Allergies:_____

Referred by:_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment to the party who accepts assignment.

SIGNATURE:_____

IF I FAIL TO CANCEL ANY FUTURE APPOINTMENTS I WILL BE CHARGED A NO SHOW FEE OF $25.00

SIGNATURE:_____

DR. ROXANNE IS NOT A MEDICARE PROVIDER SO ALL CHARGES ARE THE PATIENTS RESPONSIBILITY.

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records, examination results, medication dose changes, and claims information.
This information may be released to:

☐ - Spouse _____

☐ - Child(ren) _____

☐ - Other _____

☐ - Information is not to be released to anyone other than me.

Messages

Please call ☐ my home phone is _____ ☐ my cell phone is _____

If unable to reach me:

☐ - You may leave a detailed message

OR

☐ - Please leave a message asking me to return your call

☐ - Do not leave messages on my phone mailbox.

The best time to reach me is (day of week)_____ between (time)_____

E-mail Messages

☐ - Use my e-mail address to send messages for me to contact the nurse for information **OR**
☐ - Use my e-mail to leave detailed messages and information.

☐ Attach lab results to the e-mail message.

My e-mail address is _____

This Release of Information will remain in effect until terminated by me in writing.
This release ***specifically excludes*** any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Patient Signature: _____ Date: ____/____/____

Witness Signature:_____ Date: ____/____/____