Integrity Health Group

HIPAA/Contact Update Form

This form will be valid until the patient listed turns 18. If there are any changes that need to be made a new form will need to be filled out. When patients turn 18 they will need to complete a new form themselves.

Patient Name ______________________ DOB: __________ Patient cell: ____________

Patient Address ____

Primary Contact (parent/guardian/self): Name: ________________ Relationship: __________

Cell Phone: ________________ Address: ______________________________

Home Phone: ________________ Work Phone: ________________ Date of Birth: __________

Primary Contact (parent/guardian/self): Name: ________________ Relationship: __________

Cell Phone: ________________ Address: ______________________________

Home Phone: ________________ Work Phone: ________________ Date of Birth: __________

Emergency Contact (Optional): Name: ____________________ Relationship: __________

Cell Phone: ________________ Address: ______________________________

Home Phone: ________________ Work Phone: ________________ Date of Birth: __________

If you have any privacy preferences about any of these individuals please list them in the lines below:

____

____

____

Would you like to receive appointment reminders and medical information via calls or texts? If so please list the name and phone number of the person that will be receiving these (only one person can be listed):

Name: ______________________________

Relationship: ______________________________

Phone number for calls: ______________________________

Cell Phone Number for texts: ______________________________

DECLINE

☐ Decline automated reminder calls

☐ Decline text appointment reminders

I attest that all the information I provided above is true and accurate to the best of my knowledge. I have received and am agreeable to the terms of Integrity Health group's notice of privacy practices.

Signature: ______________________________

Name: ______________________________ Date: ____________