

Authorizations

AUTHORIZATION TO ACCESS RX HISTORY INFORMATION: I hereby authorize Draves Family Medicine to access my historical prescription drug information. Without this authorization we will not be able to prescribe any controlled substances to you.

A federal regulation, known as the "HIPAA Privacy Rule, requires that we provide you a detailed notice in writing of our privacy practices. It also requires us to address any special needs you may have to assure your patient information is kept confidential.

May we call you and remind you of your appointment? YES NO

May we leave a message on your answering machine if you are not available? YES NO

May we leave results of any diagnostic test on your answering machine? YES NO

May we call you at work with test results or other health related issues? YES NO
Work # _____

Other than yourself, do you authorize our office to discuss your health Information with another family member(s) or spouse YES NO

If so, whom _____ Relationship _____ Phone _____
_____ Relationship _____ Phone _____
_____ Relationship _____ Phone _____
_____ Relationship _____ Phone _____

**The following information is now being required for Government Reporting purposes.
Please complete ALL sections.**

Race: White Language: English Ethnicity: Non-Hispanic Birth Order 1st
 Black or African American Spanish Hispanic 2nd
 Hispanic Indian Other _____ 3rd
 American Indian or Alaskan Native Other _____ 4th
 Asian 5th
 Other _____ 6th

Patient Name _____ Signature _____

Relationship to Patient _____ Date _____