Chesterfield Family Practice Center, P. C.
HIPAA Access Form for Protected Health Information

I, ___________________________________ understand that it is the policy of Chesterfield Family Practice Center to restrict access to my Protected Health Information. My health information may be disclosed to caregiver(s) providing health services, insurance companies for payment of my claim(s), and basic healthcare operations such as pre-certifications, referrals, etc.

I give my permission for the following person(s) to have access, as indicated below, to my Private Health Information.

INFORMATION ACCESS PREFERENCES					
Name (Please Print)	DOB	Clinical		Financial	
		☐All	☐None	☐All	☐None
		☐All	☐None	☐All	☐None
		☐All	☐None	☐All	☐None

Communication Methods for Confidential Clinical/Financial Information:

☐ I do not release authorization for any confidential clinical/financial information to be given to anyone but me.

☐ You may leave confidential clinical/financial information on the following methods of communication, on my answering machine or voice mail, cell phone, voice mail at work, or you may send written communication to the address or fax number below. Please provide authorized phone numbers or addresses:

_______________________________ _______________________________
Daytime Phone Number Evening Phone Number

_______________________________ _______________________________
Patient / Legal Guardian Signature Date

_______________________________ _______________________________
Witness Signature Date