HIPAA Disclosure Form

Family Practice by the Lake
Jacqueline L Wagner, ARNP
1875 N Lakewood Dr. Ste 205
Coeur d'Alene, ID 83814
Phone: (208) 966-4087

Patient Name: _____ Date: _____

Address: _____

Mailing Address (*if different from above):* _____

Phone: _____ Cell: _____

E-Mail Address: _____

Would you like correspondence with you to be marked "Confidential"? □ Yes □ No

May we identify ourselves over the phone? □ Yes □ No May we leave messages? □ Yes □ No

I, the Patient, hereby authorize the provider and/or clinic listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, mediations, surgeries, etc.) via postal mail, telephone, fax or email to the following family members:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Patient Signature: _____ Date: _____