

# HIPAA Disclosure Form

Family Practice by the Lake  
Jacqueline L Wagner, ARNP  
1713 E Sherman Avenue  
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: \_\_\_\_\_