Dear Patient;

According to HIPAA Federal Regulations, each patient must be assured that his / her medical records are held in the strictest confidence. In order for Peconic Bay Primary Medical Care, PC to comply with those regulations, we ask that you take a moment to complete the following questionnaire.

Your signature is required where requested.

With what individuals may we discuss medical history, test, or lab results?

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Where may we contact you?:

	(Circle One)		
Home Phone:	Y	N	Number:__(____)_____
Cell Phone:	Y	N	Number:__(____)_____
Work Phone:	Y	N	Number:__(____)_____
Email:	Y	N	E-mail address:_____

I understand that Peconic Bay Primary Medical Care, PC, will adhere to the regulations as outlined by HIPAA and will follow the guidelines I have outlined above.

I have received Peconic Bay Primary Medical Care, PC notice of Privacy Practices written in plain language. The notice provides in detail the use and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my health information.

I understand that Peconic Bay Primary Medical Care, PC reserves the right to change the terms of its Notice of Privacy Practices and make changes regarding all protected health information resident at, or controlled by, this practice. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request. I also understand that without a signed consent from the patient, medical information will not be released to any unauthorized individuals.

Patient Name:_____ Date of Birth:_____

Signature of Patient:_____ Date:_____

Signature of Parent / Guardian:_____ Date:_____
(If Applicable)

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE