E. Brooks Wilkins Family Medicine, PA
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Please read and understand the Privacy Practices Notice prior to filling out this form. E. Brooks Wilkins Family Medicine, PA will try to accommodate your request, but only under the guidelines of the Privacy Practices Notice and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Internal Use

Chart #

PLEASE PRINT ALL ENTRIES

Confidential Communication: Please use the following address and/or phone number to contact me about my health information. (Please list only the address and/or phone number(s) you want used to communicate with you.

PATIENT INFORMATION				
Last name:	First Name:	Middle Initial:	Sex: (Please √ One) M____ F____	
Social Security Number*:	Date of Birth:		Marital Status: S__M__D__W__	
Address:	Apt:	City:	State:	Zip:
Home Phone: ( )	Work Phone: ( ) Ext:		Cell/Pager (←Circle One) ( )	

***Please Note: If you refuse to provide your Social Security Number to E. Brooks Wilkins Family Medicine, P.A., your insurance may be required to sign a waiver.**

Request of Restriction on Personal Uses and Disclosures About Your Health Information:

Please use this area specifying information to be restricted and the reason for this restriction. Give as many details as possible. You may use the back of this form if the given does not suffice. .

Information to be Restricted:

_____

_____

Who may see my Information and Relationship to me:

_____

_____

Who may <u>not</u> see my Information and Relationship to me:

_____

_____

Date(s) of Service for Health Information to be restricted:

_____

_____

Special Instructions:

_____

_____

X_____ _____

Patient or Guardian Signature Date Witness Signature Date