Argyle Family Practice

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HIPAA and EMERGENCY CONTACT FORM

Patient Name: _____ Date of Birth: ___/___/___

Email Address: _____

Release of information

[] I authorize the release of information including the diagnosis, records, examination rendering to me including claims and use of office equipment.

[] Spouse_____ phone number: _____ Birth date: _____
[] Child(ren)_____ phone number: _____ Birth date: _____
[] Other_____ phone number: _____ Birth date: _____
[] information is not to be released to anyone.

Please call [] Home_____ [] Work_____ [] my cell_____
If unable to reach you, may we leave a detailed message on your voicemail [] Yes [] No.

Signature: _____ Date: _____

All Forms/FMLA paperwork needing to be filled out by physician will be charged $25.00 and still may require Office Visit.

Pharmacy Information

All medication refills will need to be called into pharmacy, **NOT** the office. **Allow 72 hours.**

PREFERRED LOCAL PHARMACY (Required)

Name and Location_____

PREFERRED MAIL ORDER PHARMACY

Name and Location_____