BJC Medical Group

Name: _____

DOB:_____

Patient Communication Preferences

Phone number for voice message(s): _____

Cell number for text message(s): _____

Email address: _____

HIPAA Disclosure Authorizations(s)

Initial _____ I authorize BJC Medical Group to provide the following person(s) with my protected health information:

Print Name:_____ Relationship to Patient/Phone number _____
Print Name:_____ Relationship to Patient/Phone number _____

Initial _____ I do not authorize BJC Medical Group to:
Disclose my protected health information to anyone other than myself, except as permitted by HIPAA and as described in BJC's Notice of Privacy Practices.

Prescription Authorization

Initial _____ I authorize BJC Medical Group to allow the following person(s) to pick up prescriptions on my behalf:

Print Name:_____ Relationship to Patient _____
Print Name:_____Relationship to Patient _____

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized. I understand this authorization is valid while I continue to receive services from any BJC Medical Group provider.

_____	_____	_____
Signature of Patient/Personal Representative	Relationship to Patient	Date