BETHANY MEDICAL CENTER
HIPAA FORM

507 Lindsay Street
High Point, NC 27262

3604 Peters Court
High Point, NC 27265

3610 Peters Court
High Point, NC 27265

Phone for all locations: 336-883-0029

In accordance with regulatory standards, mandated by HIPAA, federal rules that govern the privacy of all patients, Bethany Medical Center understands that your health information is very important to you. At Bethany Medical Center we are committed to protecting your medical information and ask that you help us by completing the information below for communication purposes:

_____ _____ _____

Patient Name (Please Print) **Date of Birth** **Social Security Number**

Phone number(s) where you would want to receive calls about appointments, lab/test results, and financial information on an answering machine or voicemail?	Phone Numbers 1. 2. 3.	May we leave a message? 1. 2. 3.	
Person(s) that we may inform about your medical condition including treatment, financial & general healthcare.	Name Relation Phone #	Name Relation Phone #	Name Relation Phone #
If your place of employment or school calls to verify your appointment, may we give that information on your behalf?	Please Circle One (1) Yes No		

Rights of the Patient

I understand that I have the right to update or revoke this authorization at any time. I also understand that updating or revoking may not be effective in some cases where information has already been disclosed. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I have the right to inspect of copy my protected health care information upon written notification to Bethany Medical Center. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional upon signing. This authorization will be in effect until revoked.

_____ _____

Patient Signature or Guardian/Power of Attorney **Date**

_____ _____

Witnessed By **Date**