Orland Primary Care Specialists

16660 S. 107th Ave., Orland Park, IL 60467
708/403-8500 Fax 708/364-7080

Patient Privacy Directive

PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Date of Birth:_____ **Home Telephone #:**_____

Address:_____

Parent/Guardian Name (if Patient is a Minor) :_____ **Relationship to Patient:**_____

Please provide our office with the phone numbers(s) we or an automated service may leave messages regarding your appointments, medical care, and billing information or requests:

_____ _____

Please provide our office with the name(s) and their relationship to your or your dependent(s) in which you authorize our office to give or communicate information regarding your appointments, medical care, and billing information or requests:

_____ _____
Name of authorized person **Relationship to the patient**

_____ _____
Name of authorized person **Relationship to the patient**

_____ _____
Name of authorized person **Relationship to the patient**

_____ _____
Name of authorized person **Relationship to the patient**

Please provide our office with an email address we may communicate your health information to you:

_____

Please be aware, your must inform Orland Primary Care Specialists in writing of any changes to your directives.

I acknowledge the above listed information I have provided to be true and correct.

_____ _____ _____
Signature of Patient or Guardian **Printed Name of Patient or Guardian** **Date**

As a patient of Orland Primary Care Specialists, Inc., I have been provided with its Notice of Privacy Practices, which describes how medical Information about me may be used or disclosed, and informs me of my individual privacy rights.

I acknowledge I have received the Notice of Privacy Practices and I understand how medical information about me may be used, the duties of Orland Primary Care Specialists, Inc., and my rights to privacy protection and access to my medical information. I understand the Office Administrator of Orland Primary Care Specialists, Inc. is available to answer any questions that I may have regarding issues of privacy.

_____ _____ _____
Signature of Patient or Guardian **Printed Name of Patient or Guardian** **Date**