RICHARD K. ELIA, M.D.

Patient Information Sheet

Please Print Neatly

Patient Name_____Date of Birth_____

Permanent Mailing Address_____

City_____ State_____ Zip_____Male _____ Female_____

SSN_____Home #_____Work #_____Cell #_____

Email Address: _____

Marital Status _____ Ethnicity _____

Occupation _____**(if student, you must fill in parents address below)**

Emergency Contact_____ Phone #_____

Insurance policy holder information

Insurance Policy Holders Name_____Policy holders SSN _____

Policy holder_____Date of Birth of policy holder_____

Insurance policy holder information

Insurance Policy Holders Name_____ Policy holders SSN _____

Policy holder_____Date of Birth of policy holder_____

Parent/Guardian Information

Parent/Guardian Name_____Date of Birth_____

Address (if different from above)_____City_____

State _____ Zip _____ Home # _____ Work # _____

Relationship to Insured:_____

Your Personal Health Information is Kept Private by
In accordance with the federal HIPAA regulation, we are required to follow very strict regulation as it pertains to your health information. Please see our Notice of Privacy Practices for more specifics on this issue.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Name of patient (please print neatly) _____

Signature of Patient/Guardian _____ Date _____

RICHARD K. ELIA, M.D.
FAMILY MEDICINE
5375 North Palm
Fresno, CA 93704

Name of Patient: _____

Information to be released to: **Richard K. Elia, M.D.**
5375 North Palm **Phone: 559-435-3542**
Fresno, California 93704 **Fax: 559-431-2457**

INFORMATION TO BE RELEASED FROM:

NAME: _____

ADDRESS: _____

_____

PHONE/FAX: _____

*****All allowable fees for copies must be paid prior to receiving records*****

PLEASE SEND THE FOLLOWING:

√ **History/Physical**	√ **X-ray Reports**	√ **EKG/Treadmill**
√ **Lab Reports**	√ **Consultations**	√ **Medication List**

I understand that this authorization:

(1). Prohibits further use or disclosure of the information being released beyond the specific limits of this consent.
(2). Includes all medical records or other information regarding my treatment, hospitalization, and/or outpatient care of my condition.
(3). Expires six months from the date of signature.
(4). This authorization may be revoked at any time at my request.
(5). I understand that I have a right to receive a copy of this authorization.

_____ _____
Signature of Patient or Legal Guardian Date