Gastroenterology and
Internal Medicine Specialists, S.C.

A division of

Philip Nagel, MD
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HIPAA CONTACT FORM

Name: ______________________________________ **DOB:** __________________

*** May we leave a confidential voicemail at any of your phone numbers? If so, please list your contact numbers in the order you prefer us to call:**

1. ____________________________________ ☐Home ☐Work ☐Cell
2. ____________________________________ ☐Home ☐Work ☐Cell
3. ____________________________________ ☐Home ☐Work ☐Cell

*** If we cannot contact you, may we leave medical information with another person?**

☐YES ☐NO

Their Name: ____

Relationship: ____

*** May we disclose your medical diagnosis to a lab or pharmacy?**
☐YES ☐NO

*** May we release medical records to your Primary Care Physician/other treating Physician?**
☐YES ☐NO

Emergency Contact:

Last Name	First Name	Middle Initial	DOB
Address	City	State	ZIP
Day Phone	Alternate Phone	Relationship to Patient	

Signature____________________________________**Date**________________________

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