TEXAS NEUROLOGY

Name: _____ Date of birth: _____
First MI Last

Primary Emergency Contact

Please check a box below indicating whether or not you would like to have this Primary Emergency Contact added as an authorized HIPAA contact.

- ❑ I authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact
- ❑ I do **NOT** authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact

Name: _____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Relationship: ❑ Spouse ❑ Partner ❑ Sibling ❑ Parent ❑ Child ❑ Friend ❑ Other: _____

Secondary Emergency Contact

Please check a box below indicating whether or not you would like to have this Secondary Emergency Contact added as an authorized HIPAA contact.

- ❑ I authorize the disclosure of my protected health information to the person listed as my Secondary Emergency Contact
- ❑ I do **NOT** authorize the disclosure of my protected health information to the person listed as my Secondary Emergency Contact

Name: _____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Relationship: ❑ Spouse ❑ Partner ❑ Sibling ❑ Parent ❑ Child ❑ Friend ❑ Other: _____

Primary Care Provider

Name: _____ Phone: (_____) _____ - _____

Primary Pharmacy

Type: ❑ Local Pharmacy ❑ Mail-order Pharmacy ❑ Specialty Pharmacy

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Secondary Pharmacy

Type: ❑ Local Pharmacy ❑ Mail-order Pharmacy ❑ Specialty Pharmacy

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

x _____ x _____
Patient/Guardian Signature *Date*

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