Back to Basics Medical Practice

1503 Elm Street, Suite C
Sanford, NC 27330
Phone: (919) 895-6339 Fax: (919) 590-1981

I, _____, date of birth _____, hereby authorize **Back to Basics Medical Practice** to release my PHI or medical information to: (Specific Person(s) or entity authorized to receive PHI or medical information)

Name(s): _____

I also authorize communication between **The Family Doc** and **Back to Basics** regarding my PHI or medical information including the release of all medical records (including those related to psychiatric or mental health notes, chemical dependency, and/or the release of information pertaining to sexually transmitted diseases or related illnesses) from one entity to the other.

Please list your contact information below.

Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Fax: _____ Email: _____

Please circle preferred method of contact: Cell Phone Home Phone Email Mail

May we leave a message on your cell phone voicemail? Yes No
May we leave a message on your home phone voicemail? Yes No

Emergency Contact: _____ Relationship: _____ Number: _____

By signing below, I acknowledge that I agree with all of the information listed on this form.

Signature: _____

Print Name: _____ Date: _____

Witness Signature: _____