

**PRIME HEALTHCARE, PC**  
Gastroenterology/Internal Medicine

**HIPAA PATIENT CALLING INFORMATION**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**With whom do you allow us to share your personal medical information?**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

**How may we contact you?**

**Home Phone:** \_\_\_\_\_

- DO NOT leave a message  
 Leave brief message, return #  
 May leave a detailed message

**Work Phone:** \_\_\_\_\_

- DO NOT leave a message  
 Leave brief message, return #  
 May leave a detailed message

**Cell Phone:** \_\_\_\_\_

- DO NOT leave a message  
 Leave brief message, return #  
 May leave a detailed message

\*\*I understand that it is my responsibility to notify the office of any changes in my calling information.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_