ENGLEWOOD
COMMUNITY
CARE
CLINIC

Patient Information and Privacy Release Form

County of Residence________________

Patient Name: ____________________________________ Preferred Name: __________________

Home Address: ____

City: ____________________ State ________ Zip: ____________

Home Phone #: ______________________________ Mobile Phone #: ________________________

Consent to Text Message: Yes________ No__________ Email: ______________________________

What is the best way to communicate with you? (Circle One): Home Phone Cell Phone Work Phone Email USPS Mail

Gender (Circle): M / F Birth Date: ____/____/______ US Military Veteran (Circle One): Yes No

Family Status (circle): Single Married Divorced Separated Widowed Domestic Partner Minor Child

Spouse's Name: _______________________ Language Spoken at Home _____________________

Place of Employment: ____ Work #: _______________

Race/Ethnicity (Circle One): White Hispanic/Latino Black/African American Asian American Indian/Alaska Native Native Hawaiian/Pacific Islander Don't wish to report

How did you first learn about our clinic? (circle one):

Newspaper	Family Member	Walk-In	Advertising
Facebook	At Work	Friend/Neighbor	Internet /Online Search
Hospital	Word of mouth	Another Patient	Primary Care Physician
Sign/Drive By	Walk-In	Other________	

Emergency Contact:

Name ____ Relationship_______________________

Home #: _______________ Work #: ___________________ Mobile #: ______________________

Please sign and date each item below

To the best of my knowledge, the patient Information given is complete and accurate.

Signature_______________________________ Date___________________________

Print name____

CONSENT FOR TREATMENT, CONSENT TO SHARE and PRIVACY POLICY

I understand that by signing below, I am giving consent to **Englewood Community Care Clinic, Inc.** for treatment of my health care issues, and that I have received notice of the **HIPAA PRIVACY POLICY** of this clinic.

Signed____

Date______________________________

I authorize **Englewood Community Care Clinic, Inc.** to contact/message me by mobile phone.

Signed____

Date ______________________________

MEDICATION HISTORY RELEASE

I authorize **Englewood Community Care Clinic, Inc.** to obtain/have access to my medication history.

Signed____

Date ______________________________

Revised 8/2018

The
Englewood Community
Care Clinic, Inc.
Healthcare For Our Community

Notice of Privacy Practices

The Englewood Community Care Clinic, Inc. understands that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

WE ARE REQUIRED BY LAW TO:

- Make sure that the medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy policies with respect to your medical information;
- Follow the terms of this notice

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

1. **FOR TREATMENT:** We may disclose medical information about you to doctors, nurses and other health professionals who are involved in your medical care
2. **FOR HEALTH CARE OPERATIONS-** We may use this information to provide the best health care based on your medical information
3. **LAW ENFORCEMENT-** We may release your information if asked to do so by a law enforcement officer. Examples would include a subpoena, warrant summons, fugitive material witness, missing person, victim of a crime, criminal misconduct about a death or in emergency circumstances to report a crime
4. All other disclosures require a patients' written authorization which may be revoked at any time

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

- **RIGHT TO INSPECT AND COPY-** You may request this at any time-a charge may be assessed for copying costs
- **RIGHT TO AMEND-** You may have us update and change incorrect information
- **RIGHT TO REQUEST RESTRICTIONS-** You may request that we do not give out a particular part of your medical records to family members
- **RIGHT TO CONFIDENTIAL COMMUNICATIONS-** You may request that we only contact you a certain way, for example by telephone at home, by email or by text message

COMPLAINTS: All complaints about privacy violations or any other matter should be made to the Clinic Executive Director. You will not be penalized for making complaints. You have the right to complain to the Florida Department of Health about any violations of your privacy.

The Englewood Community Care Clinic, Inc. reserves the right to update and change this notice and post a correct version of this notice at all times.

Revised 7/2018