William A. Anderson, M.D.
800 Eighth Avenue, Suite 510
Fort Worth, Texas 76104
Phone: (817) 334-0908 *Fax: (817) 334-0989*

PATIENT NAME: _____ DOB: _____

The Health Insurance Portability and Accountability Act (HIPAA) requires that you are informed of the measures take to ensure the privacy of your medical information. Please read and answer the following questions.

Our office will share your medical records with treating physicians and healthcare providers attending to your care. We will also share appropriate medical information with your insurance carrier in order to collect payments. All other release of your medical information will require your approval. We will not release your information to marketing firms, research centers, or drug companies. Your signature represents your knowledge and acceptance of these guidelines.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

Please list below the names and phone numbers of persons you have approved of us sharing your healthcare information with.

NAME: _____ PHONE NUMBER: _____

NAME: _____ PHONE NUMBER: _____

Who can we contact in case of emergency (if different from the above)?

NAME: _____ PHONE NUMBER: _____

SECOND NUMBER: _____

Can a confidential message be left on your answering machine or voicemail? [ ] YES [ ] NO

If you feel this office has mishandled your medical information or if you have a complaint, please contact our Business Manager, Linda Burton, 817-927-2924 ext 104.

Would you like a copy of this form for my records? [ ] YES [ ] NO