CAPITAL NEUROLOGY
4250 CRUMS MILL ROAD STE 102
HARRISBURG, PA 17112-2889
(717) 649-0211

PATIENT CONFIDENTIALITY AND CONTACT INFORMATION FORM

It is the policy of Capital Neurology to release confidential information only with the authorization of the patient, unless otherwise permitted or required to by law.

I understand that I will receive correspondence through the U.S. Mail. I authorize Capital Neurology to provide or leave messages regarding scheduling or routine medical information pertaining to my care, such as a normal test with the following authorized individual(s):

Please list the names of, and your relationships with, the authorized person(s) (e.g. spouse, parent, child), with whom we may discuss your medical care.

NAME:	RELATIONSHIP:	TELEPHONE NUMBER:	MEDICAL INFO. TO BE SHARED:	METHOD:
			☐ All medical information ☐ Appointment information ☐ Info. restricted to (indicate): _____	☐ Telephone ☐ Voicemail ☐ In-person
			☐ All medical information ☐ Appointment information ☐ Info. restricted to (indicate): _____	☐ Telephone ☐ Voicemail ☐ In-person
			☐ All medical information ☐ Appointment information ☐ Info. restricted to (indicate): _____	☐ Telephone ☐ Voicemail ☐ In-person

PATIENT CONTACT INFORMATION: please indicate where we may attempt to call you.

Home	☐ YES ☐ NO	Telephone: ( ) ____ – _____	Leave message?	☐ YES ☐ NO
Work	☐ YES ☐ NO	Telephone: ( ) ____ – _____	Leave message?	☐ YES ☐ NO
Cell Phone	☐ YES ☐ NO	Telephone: ( ) ____ – _____	Leave message?	☐ YES ☐ NO

SIGN: I understand that I am responsible for notifying Capital Neurology when any of this information changes.

_____	_____	_____
Signature of patient	Print name of patient	Date of birth
_____	_____	_____
Signature of parent/guardian	Print name of parent/guardian	Today's date