Date_________________

GARRICK P. HUBBARD, M.D. JENNY V. CASBURN, FNP-C MEGHAN M. CARLSTEDT, PA-C

Name_______________________________ ____________________ _________ ___________ Male/Female
Last First Middle Nickname Single/Married
Address__________________________________________City_______________________State_________

Zip_______ Home Phone # ( )________________ Cell Phone # ( )_________________ Preference : Home/ Cell

Social Security#______________________DOB______________ Email Address:________________________

Employer_______________________________________Address________________________________________

City _____________________ State _________________Zip ________Work Phone# ( )___________________

If patient is a minor, provide Mother's Name _________________________Father's Name _________________________

## PRIMARY INSURED PARTY INFORMATION

Name______________________________________________ Male Female DOB____________
Last First Middle

SS# _____________________Relationship to Patient _____________________ Home Phone# ( )________________

Address __________________________________City _____________________________State______ Zip_________

Employer_______________________________________Address________________________________________

City___________________ State__________ Zip________ Work Phone# ( ) ______________________

## SECONDARY INSURED PARTY INFORMATION

Name______________________________________________ Male Female DOB____________
Last First Middle

SS#______________________ Relationship to Patient ____________________Home phone # ( )________________

Address___________________________________City____________________________ State _______Zip_________

Employer_______________________________________Address________________________________________

City_____________________State___________Zip_________Work Phone # ( )___________________

**EMERGENCY CONTACT**

Name _________________________Relationship ______________Phone#______________Cell#_________________

**PRIMARY CARE PHYSICIAN**

Name ________________________ Address____________________________________Phone#_________________

**REFERRED BY**

Name ________________________ Address____________________________________Phone #_________________

# Allergy and Asthma Care of Indiana

Garrick Hubbard, MD ▪ Jenny Casburn, NP-C ▪ Meghan Carlstedt, PA-C
Main Phone 317 708 2839▪ Fax 317 708 2877
11590 N Meridian St #400 Carmel, IN 46032▪227 S. Delaware St, Indianapolis, IN 46204▪One Memorial Sq. #330 Greenfield, IN 46140


## Limited Patient Authorization for Disclosure of Protected Health Information to an Individual

**Please print all information. Form must be signed and dated in order to be valid**.

Patient Name:_______________________________________________________DOB:______________________

Please indicate below if it is okay to leave protected health information via voicemail(s) on your home and cell

**□ Yes □No or please indicate phone number(s)______________________________**

**I authorize Allergy and Asthma Care of Indiana to disclose or provide protected health information about me to the individuals listed below: (no need to list physicians)**

Name:____________________________________________Relationship:_______________________________

Phone 1:__________________________________________Phone 2:___________________________________

Name:____________________________________________Relationship:_______________________________

Phone 1:__________________________________________Phone 2:___________________________________

Name:____________________________________________Relationship:_______________________________

Phone 1:__________________________________________Phone 2:___________________________________

Information to be disclosed may include medical or financial information such as lab or x-ray results, current health record, previous/other provider health records, and/or payment information.

Or (please specify) only the following information:___________________________________________________

You have the right to terminate this authorization at any time. You must notify us in writing if you decide to terminate the expiration prior to the end of the signed calendar year.

You are in no way obligated to sign this form in order to receive medical treatment.

We have no control over the person(s) you have listed to receive your protected health information and cannot be responsible for how they choose to use or share the information once it is disclosed.

_____________________________________________________________________________________________

Patient Signature Date

You have a right to receive a copy of signed authorizations upon request.