SP ASSOCIATES

◯ Replace my privacy policy contacts

Patient Privacy Form

◯ Add to my privacy policy contacts

In addition to my emergency contacts, I authorize Statesboro Psychiatric Associates to talk with the following parties regarding my treatment and appointments, to pick up prescriptions per my request, and bring minor children to their appointments as applicable:

Name:_____ Relationship:_____

Phone:(H)_____(W)_____(C)_____

Address:_____

Name:_____ Relationship:_____

Phone:(H)_____(W)_____(C)_____

Address:_____

Name:_____ Relationship:_____

Phone:(H)_____(W)_____(C)_____

Address:_____

Name:_____ Relationship:_____

Phone:(H)_____(W)_____(C)_____

Address:_____

- I understand that in addition, SPA can provide treatment information to other providers for the purpose of coordination of care. This includes my primary care physician, referring physician, and other health care providers involved in my care.
- In the case of a child, I understand that in many circumstances, a custodial parent or legal guardian other than the person bringing the child to appointments may have legal right to obtain the medical records of the minor.

********************YOUR SIGNATURE IS REQUIRED EVEN IF NOT LISTING ANYONE ON THE PRIVACY FORM*********************

_____ _____

Print Patient's Name Patient's Date of Birth

_____ _____

Signature of Patient * Digital Signature Date

_____ _____

Signature of Parent/Guardian/Personal Rep * Digital Signature Date