Dr. Glenda Thomas, DNP, FNP-C

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1. PATIENT INFORMATION			
Last Name, First Name, Middle Initial		Date of Birth	Social Security Number
Mailing address	City	State	Zip code
Primary phone # Cell Work Home	Secondary Phone # Cell Work Home		Email Address
Emergency Contact Name and Phone number		Relationship to patient	

CONTACT INFORMATION & AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION (PHI)			
I give permission for Dr. Glenda Thomas DNP, FNP-C or staff to disclose my personal health information (PHI) with the following person(s):			
Name:	Relationship	Phone #:	Restriction (if any):
Name:	Relationship	Phone #:	Restriction (if any):
I understand I may revoke this consent at any time. I also understand that my personal health information (PHI) will not be released without this consent.			

Patient Authorization

I hereby authorize Dr. Glenda Thomas, DNP, FNP-C (VeneSalud Primary Care) to release any information acquired in the course of my examination or treatment necessary to process insurance claims. I assign any benefits payable by my insurance carrier to the provider services submitting a bill for the services rendered. I further authorize the release of any necessary information, including medical for any related claim to the above insurance company. I accept financial responsibility for any collection/attorney fees the physician incurs in collecting payments for which I am responsible. A copy of this agreement may be used in place of the original. This authorization may be revoked at any time in writing. I certify that all the above information stated on this form is true and accurate.

_____ _____

Signature of Patient or Parent/Legal Guardian Date