3320 WAKE FOREST RD. SUITE 430 ~ RALEIGH, NC 27609
919.876.7676 PHONE 919.876.7163 FAX

PATIENT LIST OF PHI RECIPIENTS

For Office Use Only

Chart Number: ____________________

NOTICE:
TO AVOID ACCIDENTAL DISCLOSURE YOU MUST PROVIDE THE FOLLOWING INFORMATION OR YOUR NOTES *WILL NOT* BE FORWARDED:

1) Complete names and addresses of physicians
2) Name and fax numbers of caseworker if this is a worker's compensation case

YOUR OFFICE NOTES WILL BE SENT TO THE PHYSICIANS YOU LIST BELOW:

Who is your Primary Care/Family Physician?

First Name: ____________________ Last Name: ______________________________

Address: ____

City, State, Zip: ________________________________ __________ __________

☐I do not have a primary care/family physician

Who is the Physician that REFERRED you to this office?

First Name: ____________________ Last Name: ______________________________

Address: ____

City, State, Zip: ________________________________ __________ __________

Have you received treatment by another Physician/Healthcare Provider regarding your current condition?

______________________________ ______________________________________
Name Address

______________________________ ______________________________________
Name Address

IF APPLICABLE: Give your Workers' Compensation Case Manager/Caseworker's Name and Fax Number:

Name: ____

FAX NUMBER: (____) ________________________

NAME: ____ **Date of Birth:** __________

MEDICAL PROVIDER:
If this is a worker's comp case and this information is missing, please turn to the worker's comp sheet

IF AVAILABLE:
PLEASE STAPLE
CASE MANAGER'S BUSINESS
CARD HERE