THE CENTER FOR SAME DAY SURGERY

Patient Label

PATIENT HIPAA/DRIVER INFORMATION FORM

TODAY'S DATE_____ PATIENT NAME_____

NAME OF YOUR DRIVER _____RELATIONSHIP_____
PHONE NUMBER OF DRIVER_____ WILL THEY REMAIN IN FACILITY_____

FOR MINORS-PARENT OR LEGAL GUARDIAN MUST REMAIN IN THE FACILITY

***CAN INFORMATION BE SHARED WITH YOUR DRIVER _____
COMMENT_____

MINORS-NAME OF LEGAL GUARDIAN IF **NOT** THE PARENTS_____

MUST HAVE LEGAL DOCUMENTATION AVAILABLE IF GUARDIANSHIP

NAME OF CASE MANAGER IF APPLICABLE_____

DURABLE POWER OF ATTORNEY (DPOA) NAME IF NEEDED_____

MUST HAVE LEGAL DOCUMENTATION AVAILABLE IF DPOA SIGNING

***__EMERGENCY CONTACT__ NAME IF DIFFERENT THAN DRIVER_____
RELATIONSHIP_____ PHONE NUMBER_____

IN CASE OF EMERGENCY THIS PERSON WILL BE NOTIFIED AND GIVEN NEEDED INFORMATION

HIPAA-

***IN ADDITION TO YOUR DRIVER (IF PERMISSION ABOVE), AND YOUR EMERGENCY CONTACT
LIST ANY OTHER PERSONS WHO MAY HAVE INFORMATION ABOUT YOU WHILE IN OUR FACILITY
NAME/RELATIONSHIP

1._____/_____
2._____/_____
3._____/_____
4._____/_____

PERSONS NOT LISTED WILL NOT BE GIVEN INFORMATION WHILE YOU ARE A PATIENT IN OUR FACILLITY

1st Visit-Patient/Guardian Signature_____ Date_____

I Attest by signing below that there are no changes to the above information

2nd Visit-Patient/Guardian Signature_____ Date_____

3rd Visit-Patient/Guardian Signature_____ Date_____

4th Visit-Patient/Guardian Signature_____ Date_____