State Employees' Insurance Board Healthcare Center (SEIB HCC)

Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:**
Insurance Contract Number:	**Insurance Group Number:**		
Subscriber Last Name:	**Subscriber First Name:**	**Middle Initial:**	**Date of Birth:**
Address (Street, City, State, Zip):	**Contact Phone Number:**		
Email Address:	**Pharmacy:**	**Primary Physician:**	

Request SWC staff communicate with me in a confidential manner by using the following methods of communication and contact information when wishing to reach me:

If contacting me in writing:

☐ **Same as address above OR** ☐ _____

Address City State Zip Code

If contacting me by telephone: *(Check all that apply)*

☐ **Talk to me only** ☐ **May leave message with person answering phone** ☐ **May leave message on voicemail**

If contacting me electronically:

☐ **Same as email above OR** ☐ _____

Please list anyone that you give permission for us to discuss your personal health information with:

_____ _____

Name **Relationship to Patient**

_____ _____

Name **Relationship to Patient**

Understanding and Acknowledgement

1. I acknowledge that by requesting confidential communications I may prevent the use and disclosure of my PHI to family members, friends, caregivers, and others that might be for my benefit.

2. I understand that I am responsible if the contact information provided above is incorrect, or if it is later changed and I fail to report the change.

_____ _____

Signature of Person Submitting Request Date

AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR SERVICE. I hereby consent to the services provided by the State Employees' Insurance Board Healthcare Center (SEIB HCC). I understand that these services may include limited physical assessment, lab testing and non-invasive testing along with cognitive services._____(initial)

PRIVACY POLICY. I acknowledge having received the SEIB HCC's, "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explain in the Policy. I understand that I may revoke my consent for release of my health care information in writing, except to the extent the SEIB HCC has already made disclosures with my prior consent._____(initial)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.
I authorize use and disclosure of my personal health information for the purposes of diagnosis or treatment, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the SEIB HCC. I authorize the release of any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the SEIB HCC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent._____(initial)

_____ _____ _____

Patient of Authorized Person Signature Relationship Date