Clear Lake
Internal Medicine
Donna Sue Dolle, M.D.

Notification Form

Please indicate your preferred method of contact regarding any issues. Feel free to tell Dr. Dolle how you feel about discussing your medical issues by email, phone, fax, etc.:

_____

_____

(Optional) Please list all persons with whom Dr. Dolle **may** discuss your personal health information. Please include each person's relationship to you (this may be changed at any time).

_____

_____

(Optional) Please indicate if there is anyone to whom you **DO NOT** want Dr Dolle to release your personal health information.

_____

Please provide insurance information so we may share with laboratory and other providers for billing purposes.

Insurance Co. Name: _____ Insured Name: _____

Insured's DOB: _____ Policy ID# _____

Patient *Emergency* Contact (in case patient can't be reached): Name: _____

Contact Information: _____

I have reviewed this office's Notice of Privacy Practices which is posted in the waiting room. I understand that I am entitled to receive a copy of this document upon request. I authorize payment of medical benefits to this provider for medical services rendered. I authorize the release of medical records or any other information to process claims for medical services. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth