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## HIPAA FORM

### Patient Contact Information:

Your name: \_\_\_\_\_

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Work #: \_\_\_\_\_

Can we leave normal results on your answering machine/voicemail?

YES

NO

### Emergency Contact Information:

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Phone #: \_\_\_\_\_

Besides you, is there anyone we can talk to about your results?

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Phone #: \_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_