MARSHALL COUNTY HEALTH DEPARTMENT
CLIENT REGISTRATION FORM

GUARANTOR INFORMATION (person responsible for payment/billing)

Name: _____ _____ _____ Sex:_____ Race:_____
(First) (MI) (Last)
Address: _____City/State: _____ Zip:_____

DOB: _____-_____-_____ Home/Cell Phone_____ Work Phone_____ SS#_____

Listing of Family Members under the age of 18:
_____DOB:_____SS#_____
_____DOB:_____SS#_____
_____DOB:_____SS#_____
_____DOB:_____SS#_____
_____DOB:_____SS#_____
_____DOB:_____SS#_____
_____DOB:_____SS#_____

HIPPA WAIVER

Because the Marshall County Health Department is bound by the rules of the Health Insurance Portability and Accountability Act (HIPAA), we are unable to provide any information to any person other than you without your consent. This includes information about your account, your immunizations, health history, prescriptions and any other information contained in your records with us. Please list below any person or agencies that we have your permission to release your information and the information of the above family members to, if requested.

Father_____ Mother_____
Spouse_____ School_____
Siblings_____ Daycare_____
Other_____ Other _____

I acknowledge that I have received a copy of Marshall County Health Department's Notice of Privacy Practices with the effective date of April 14, 2003.
I certify that the above information is correct to the best of my knowledge. I understand the GUARANTOR listed above will be responsible for any services provided which insurance does not cover.

IF WE ARE FILING INSURANCE:
Insured or authorized person's signature: I authorize payment of medical benefits to Marshall County Health Department. I also authorize the release of any medical or other information necessary to process this claim.

Authorized Signature: _____ Date_____
Rev 5/12