MEDICAL STAFF CONTACT INFORMATION

Print Name _____

Personal Contact Info: (Confidential for use by Medical Staff only)

Home Address_____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Email Address: _____

CC Email Address: _____

Office Contact Info: (For Patient Care Needs)

Clinic/ Office Name_____

Address _____

City, State, ZIP _____

Office Telephone # _____ Fax # _____

Back Office # _____ Employer _____

Signature: _____**Date:** _____

El Camino Health has implemented appropriate physical safeguards to ensure that the location of, access to and use of client's fax machine and mailing information complies with state and federal laws and regulations controlling the privacy of PHI including; but not limited to, HIPAA.
This Authorization will remain valid until revoked or changed by the practitioner.

Change or revoke Fax Authorization:
Practitioner must provide written notice to **El Camino Health Medical Staff Services Department** at least five days prior to the implementation of the requested change or revocation. **Notices may be faxed to ECH MSSD (650) 966-9263, or emailed to** MedicalStaffOffice_@elcaminohealth.org