HIPAA Release of Information

HIPAA dictates that our office must do everything possible to protect your medical information. For this reason please indicate below who we may leave messages with or talk to regarding appointments, prescriptions, test results, surgery, dates and any other medical need we may have. Please list the phone number below where you can most likely be reached during our business day.

Phone #:

Is it ok to leave a message? Y N

I will allow medical information and test results including abnormal results and appointment information to be released to the following people:

Full Name	Relationship	Phone

* I DO NOT want medical information, test results released to anyone BUT myself. This form will be valid until revoked by me in writing

HIPAA Acknowledgement Form

I hereby acknowledge by signature below that I have been given a copy of the HIPAA Privacy Policy for review. I also acknowledge that I have read and been given an opportunity to ask any questions related to my privacy rights. This form is to be retained in my medical chart until revoked by me in writing.

Patient Signature: Date: