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RELEASE OF CONFIDENTIAL INFORMATION

This disclosure pertains to HIPAA – The Health Insurance Portability and Accountability Act of 1996, also known as Kennedy-Kassebaum Act. HIPAA calls for, among other things, security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present and future. Your medical records will be kept confidential and only you the patient will have access to them, except in certain circumstances, for example for billing purposes, your insurance company may request your records in order to clear a claim. When you signed with your insurance company you already signed for the release of relevant records if necessary. Also, when you need authorization from your insurance company to see a specialist, your insurance company may request a copy of your records. In order to continue your care through a specialist, we may fax or mail or give verbal knowledge of your medical history to the specialist. A copy of the "Notice of Privacy Practices" is enclosed in this document for your review.

_____ (Initials)

This is to inform you that due to Federal Law (HIPAA), effective April 15, 2003, we may only release medical information to the following:

1.) Healthcare providers involved in your care
2.) Insurance companies to secure payment
3.) Laboratories involved in your care
4.) Attorneys with your permission

By HIPAA standards, we are not allowed to discuss your medical problems with your spouse, significant other, or adult children. Please indicate if you would like us to speak with your spouse/significant other, or adult child if and when the need arises. Note: if you decide to revoke your permission at any time, we will need a written revocation.

YES, you have my permission to discuss any medical matters pertaining to my health with:

_____ (name of person, please print) _____ relationship
_____ (name of person, please print) _____ relationship
_____ (name of person, please print) _____ relationship
_____ (name of person, please print) _____ relationship

Signature: _____ Date: _____

By HIPAA standards, we are not allowed to leave results of your lab tests, x-rays, diagnostics, medications, etc., related to your specific health condition on your voicemail, answering machine, fax, etc. However, if you feel that your message retrieval system is safe and your information is protected, you must give us your written consent to allow us to leave your information on your messaging systems. Please choose one of the options below. Note: if you would like to revoke your option at any time, we will need your written notification.

_____ (Initials)

Appointment reminders and any information regarding your treatment may be called to (check below)

_____ My home phone/voicemail
_____ My cell phone/voicemail
_____ My office phone/voicemail
_____ Other, please indicate

_____

_____ (Initials)

I have a copy of the "Notice of Privacy Practices" & have reviewed it

Patient's name printed: _____

Patient's signature: _____

Date: _____