Perry Family Practice

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HIPPA Release Form

Name: ____ Date of Birth_____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____
[ ] Child(ren)____
[ ] Other____
[ ] Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home ____________ [ ] my work____________ [ ] my cell ______________

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] leave message with____
[ ]____

Notice of Health Information Privacy Acknowledgement of Receipt

I have acknowledged that I have received a copy of Perry Family Practice, LLC's Notice of Privacy Practices. This notice describes how they may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. This information is accessible in our lobby and you may ask for a copy at any time.

___________________________________ ________________________
Signature of Patient or Personal Representative Date

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Relationship to Patient