Receipt for HIPAA Privacy Notice and Authorization to Obtain or Release Information (MR119)

NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained or released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that **I may revoke this authorization at any time by notifying Medical West** in writing, but if I do it will not have an effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise.

I hereby authorize Medical West to disclose health information to the following:

Release to _____ Relationship to patient _____
NAME

Phone ( ) _____ Cell ( ) _____

Release to _____ Relationship to patient _____
NAME

Phone ( ) _____ Cell ( ) _____

PLEASE NOTE THAT NOT ANSWERING THE QUESTIONS BELOW MAY RESULT IN THE STAFF OF MEDICAL WEST LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE.

YES NO The physicians and staff of Medical West may confirm my appointment to my answering machine at the number provided on my patient information sheet.

YES NO The physicians and staff of Medical West may leave lab results or results of other diagnostic studies (e.g., MRI, CT, Bone Scan, etc.) on my answering machine.

YES NO The physicians and staff may release information to my pharmacy without prior authorization in order to allow call in of a prescription.

Special Instructions: _____

My Signature below is acknowledgement that I have received a copy of the Medical West Privacy Notice (MR119) and that I agree to the conditions stated in this notice.

Patient Signature _____ Date _____

HIPAA

Patient Copy