AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

Name of patient: _____ **Date of birth:** _____
(please print last name, first name)

Under the *Healthcare Insurance Portability and Accountability Act (HIPAA)* guidelines, Elizabeth Yang, M.D., P.A. must have your written and signed consent to use and disclose your health information for the following purposes:

- **For treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, and other personnel who are taking care of you and your health.
- **For payment.** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or third party.
- **For healthcare operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.
- **For family and friends.** We may disclose health information about you to your family members or friends as directed by you (see below).

Please complete the following items

1) Please list the family members and/or friends to whom we may disclose/discuss your health or treatment information or payment arrangements. You have the right to limit disclosure of any information.
_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____

2) If you would like your test results, correspondence, billing statements to be mailed to an address other than your home, please list it here.
_____

3) Please identify where you would like us to call to remind you of your appointment or to give you test results:
☐ Home ☐ Work ☐ Cell ☐ Other (please specify) _____
Do we have permission to leave a phone message on an answering machine? ☐ Yes ☐ No
Do we have permission to fax correspondence to you at the phone number you identify? ☐ Yes ☐ No

Comments: _____

I understand that I may request a copy of the "Notice of Privacy Practices" which will describe more completely the above information.
I also understand that I may list in the comment section any limitations regarding the disclosure of my protected health information. My signature is valid from this date unless I revoke this permission in writing.

X _____ **Date:** _____
Signature of patient or guardian

Name of the guardian: _____