PTPnv

**Authorization for Release of Protected Health Information**

**Privacy Practices Acknowledgement**

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide quality medical care, to obtain payment for services provided to you and to enable us to meet our professional and legal obligations to operate this medical practice properly. For a complete description of how your protected health information is used, please review the Privacy Practices HIPAA brochure.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (*PHI).* The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

**Privacy Practices**

**I wish to be contacted in the following manner (check all that apply):**

► Verbal Communication by telephone:

 

► Written Communication





Email Address: Email

**Authorization to Release PHI**

***I authorize PTP to disclose and release my protected health information described below to:***

|  |  |
| --- | --- |
| Name: Click here to enter text. | Relationship: Click here to enter text. |
| Name: Click here to enter text. | Relationship: Click here to enter text. |

***I hereby authorize the release of PHI to the individuals listed above, as follows (check one)***

 

 

 

|  |  |
| --- | --- |
| Patient Name:Click here to enter text. | Date of Birth: DOB |
| Signature: Click here to enter text. | Date: Date |