HIPAA Permission for Release of Information

Patient Name:_____

In order to comply with specific rules regarding HIPAA (Health Insurance Portability & Accountability Act of 1996), we ask that our patients review and sign a privacy and security of health information document.

It is the office policy of Dr. Singer Medical Center <u>not</u> to release confidential and/ or unauthorized information by home telephone, answering machine, work telephone, voicemail, or cell phone. Whenever returning telephone calls and the answering machine picks up, we cannot leave a message if the name and telephone number is not the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I authorize Dr. Singer and Staff to leave medical information pertaining to my care by the following methods and will assume responsibility of notifying the Medical Center whenever this information changes.

Home Telephone	_____Yes	_____No	_____N/A
Answering Machine	_____Yes	_____No	_____N/A
Cell Phone/Cell Voicemail	_____Yes	_____No	_____N/A
Work Telephone	_____Yes	_____No	_____N/A

The patient must sign the appropriate release of information before any health information will be released to the following:

Other Physician Office	_____Yes	_____No
Insurance Company	_____Yes	_____No

If you would like to have information released to someone other than yourself, please complete the following:

Please list the names of people authorized to receive your health information:

Spouse Name:_____	_____Yes	_____No
Parents Name:_____	_____Yes	_____No
Guardian Name:_____	_____Yes	_____No
Other Names:_____	_____Yes	_____No

Patient Signature:_____ Date:_____
or Guardian