

Fadi Atassi, MD Edward Quinn, MD Zeeshan Zahid, MD G. Mason Garcia, MD Homam Moussa Pacha, MD Kanaan Abow Alkheir, MD George, Jolly, MD Duane Schuil, MD, PhD Trish Folden, FNP-BC Paul Mahnke, ACNP-AG

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

		the Notice of Privacy Practices, detailing leral and state law, and outlining my rights		
Signed:			Date:	
Relationship (if not	signed by patient):		
I wish to place the f	ollowing restrictio	ns on disclosure of my health information	:	
Internal Hea Only				
Internal Use Only:	oresentative refuses to	sign acknowledgement, please document date and	time notice was presented to patient and sign below.	
Presented on (date and	d time):	oigh downowledgement, predect decument date and		
Please name all pe	rson(s) we can co	ontact and / or discuss your medical inforn	nation:	
Name:		Relationship:	Phone:	
Name:		Relationship:	Phone:	
Name:	····	Relationship:	Phone:	
Name:		Relationship:	Phone:	
□ Yes □ No	The office may leave messages on any answering machine or voice mail associated with any telephone numbers (direct or cellular) identified by me in my patient information. List any restrictions to the information that may be left on answering machine or voice mail:			
Following HIPAA pa	atient confidentiali	ty regulations, please check how you wou	ıld like us to address you:	
Mr.	And / Or	First Name		
Mrs.		Last Name		
Miss		Other:		
Ms.				
None				
Signature:			Date [.]	