HIPAA Medical Release Form

Health Insurance Portability and Accountability Act – Privacy Form

ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES & PERMISSION TO SHARE HEALTH INFORMATION

_____

Patient Name (please print)

I understand that my medical records are protected by federal law and that the information can only be released as per the Health Information Privacy and Portability Act. *(A copy is available upon request at the front desk)*

☐ All Forms ☐ Electronic copy or web-based portal ONLY ☐ Hard Copy ONLY

NOTIFICATION OF FAMILY AND FRIENDS

I hereby authorize **EMPLOYEE WELLNESS, P.A.** to disclose my protected health information to the following individual(s):

_____	_____	_____
Name	Email	Phone/Fax
_____	_____	_____
Name	Email	Phone/Fax

I understand that the above may not be covered by state/federal rules governing privacy of data and may be permitted to further share information provided to them.

NOTIFICATION OF PHYSICIANS

I hereby authorize **EMPLOYEE WELLNESS, P.A.** to disclose my protected health information to the following physician(s):

_____	_____	_____
Physician Name or Practice	Email	Phone/Fax
_____	_____	_____
Physician Name or Practice	Email	Phone/Fax

I understand that the above may not be covered by state/federal rules governing privacy of data and may be permitted to further share information provided to them.

NOTICE OF VOICEMAIL AND MESSAGES

Voice messages may be left on the phone number(s) provided: ☐ YES ☐ NO

This includes lab results, medications or any other pertinent information about your health care and health records.

RESTRICTIONS ON THE USE & DISCLOSURE OF YOUR HEALTH INFORMATION

I understand that I may request certain restrictions on the use and disclosure of my health information.
I REQUEST THE FOLLOWING RESTRICTIONS:

☐ Mental Health Records

☐ Communicable diseases including, but not limited to, HIV/AIDS, Alcohol/Drug abuse, Genetic information

☐ Other (Specify) _____

_____ _____

Signature of Patient Date

I understand that I can revoke this authorization to share my health data at any time by submitting a request in writing to: ***EMPLOYEE WELLNESS, P.A.***