PATIENT HIPAA ACKNOWLEDGMENT AND AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION (PHI)

I have been given a copy of Internal Medicine and Pediatrics Associates, PA's Notice of Privacy Practices, version effective 02/22/2022. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative Date

_____ _____

Print Name Relationship of Representative to Patient

Authorization to release PHI to family members, friends, caretakers YOU MAY REFUSE TO SIGN BELOW

By signing below, you acknowledge and agree that Internal Medicine and Pediatrics may use or disclose Protected Health Information to the persons you write below. ***This information will include Voicemail messages, Billing Information, and Lab Results unless our office is otherwise notified****.*

Full Name (printed)	*Date of Birth*	*Relationship*
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

Signature (patient/patient representative) *Relationship to Patient* *Date*

_____ _____

Full Name (Print) *Date of Birth*

Date: Expiration Date – Indefinitely unless otherwise notified/stated