DOCTORS MED CARE

Privacy & Confidentiality Notice Acknowledgement
(Reference Federal Register 45 C.F.R. § 164.506)

I understand that protected health information may be used and disclosed to perform treatment, payment and/or health care operations. I acknowledge I've been given the opportunity to read, review, and obtain a complete copy of the Doctors Med Care Privacy Notice with a complete description of such uses and understand I had a right to review the privacy notice before signing below. I understand I have a right to request this office to restrict how my information is used, but this office may not agree with the requested restrictions. I have a right to revoke this authorization and consent, in writing, at any time.

This office reserves the right to amend the privacy policy, whether required by law or otherwise, and a revised notice may be obtained by calling our office or physically coming to our office.

I authorize this office to leave messages on my answering machine regarding protected health information: ☐ YES ☐ NO

Preferred method of contact: ☐ PHONE ☐ MAIL ☐ PATIENT PORTAL

Designated Party Authorization for Release of Medical Information (Optional)

Some patients prefer that other individuals, especially family members, be allowed access to their medical information. In order to comply with strict legal standards, a written release is required to allow another person access to your medical records.

This release grants permission to individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication and will be in effect unless I notify this office of any changes or revocations.

1. Designated Party/Relationship: ____________________________ Phone: __________________
Should this person also be able to make inquiries about or pay balances on my account? Y or N

2. Designated Party/Relationship: ____________________________ Phone: __________________
Should this person also be able to make inquiries about or pay balances on my account? Y or N

This authorization for release of medical information is valid until revoked by written notice or replaced with an updated authorization.

Signature: ____ Date: ________________________