Patient Authorization for Disclosure of Protected Health Information

I, _____ , D.O.B. _____
authorize Dr. Comstock and/or staff to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, make cancellation, and tender payment on my behalf.

Name: _____

Name: _____

Name: _____

Name: _____

Signature _____ Date _____

Witness _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

According to HIPAA and Governmental rules all patients are asked to sign this release form. This notifies the office that you understand we follow all HIPAA rules by acknowledging this information sheet.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name: _____ Date of Birth: _____

Person(s)/organizations authorized to receive and use this information:

☐ Insurance Company

☐ Pharmacy (Release of name, date of birth, allergies only)

☐ Significant Other or Family Member: _____

☐ Physician: _____

Information that may be used/disclosed:

- Record of visits (all)
- History & Physical
- Progress Notes
- Lab Reports
- Medication Records
- Consultation Reports
- Problem List
- Statement of Charges/Payments

1. I understand that my health care will not be affected if I do not sign this form.
2. I understand that I may revoke this authorization at any time by notifying the office in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. **I UNDERSTAND THIS IS NOT IN RELATION TO REQUESTING MEDICAL RECORDS FOR MYSELF OR ANOTHER DOCTOR. THERE IS A SEPARATE FORM THAT IS FILLED OUT FOR THAT REQUEST WHICH I CAN OBTAIN BY CONTACTING THE MEDICAL RECORDS DEPARTMENT.**

_____ _____

Signature of Patient or Representative Today's Date

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received Lifestyle Spectrum, L.L.C. Notice of Privacy Practices.

_____

Name

_____

Signature

_____

Date

Do you give us permission for you to receive our services and product information by e-mail?

□ Yes □ No

Do you give us permission to remind you by telephone of an appointment at home or at work?

□ Yes □ No

If yes please write phone number you prefer_____

This acknowledgement page should be retained by patient's record. If acknowledgment could not be obtained from patient, the reasons must be documented below.

_____
_____
_____
_____
_____
_____