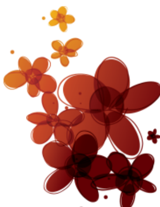

KINGSTOWNE
INTERNAL
MEDICINE

Authorization to Disclose Health Information

Date: ___________________

Patient Name: ____ DOB: __________________________

Address: ____

Home #:____________________________ Cell#:________________________ Work # ______________________

As required by the privacy regulation, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

Additional Contact Information

Name	**Phone**	**Relationship to Patient**

I give Kingstowne Internal Medicine permission to leave my results or any pertinent medical information on my home voicemail or cell phone. *Please circle:* YES **or** No

My signature verifies that this request accurately reflects my wishes. I understand that this form is valid for 1 year from date of signature. It is my responsibility to notify Kingstowne Internal Medicine of any changes prior to the expiration of this form.

____

Signature Date

Refusal to Sign Only

I understand that if I do not sign this document it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information.

Refusal to Sign Signature: ____ Date:________________

Witness Signature: ____ Date: ________________