associates in PRIMARY CARE

**HIPAA**

Within the Health Insurance Portability and Accountability Act (HIPAA) we would like to secure your privacy when it comes to talking to family, friends, and others in your life. Please fill out the below document if there is anyone you are choosing our office to release information to about your medical records.

| _____ | _____ | ☐ |
|---|---|---|
| Your name (First, Last) | Today's date | Yes, disclose info |

I hereby authorize Associates in Primary Care to disclose any protected health information about me as described to the following people listed below. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations. I also understand that I may revoke this authorization by notifying Associates in Primary Care in writing. I also understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether I sign the authorization.

The following people **may** receive disclosure of protected health information:

| _____ | _____ | _____ |
|---|---|---|
| Name (First, Last) | Phone number | Relationship |
| _____ | _____ | _____ |
| Name (First, Last) | Phone number | Relationship |

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If you choose to not release information to any person, please write your name below and select the "Do NOT disclose" box.

| _____ | _____ | ☐ |
|---|---|---|
| Your name (First, Last) | Today's date | Do NOT disclose |