Biebel & DeCotiis Podiatry Associates

Podiatric Medicine – Foot & Ankle Surgery

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative clinical staff to disclose the following protected health information to:

- ☐ Myself only
- ☐ My spouse, significant other or parent (specify name) _____
- ☐ Other (specify name) _____

Information to be disclosed:

- ☐ Laboratory results
- ☐ X-Ray results
- ☐ Diagnosis
- ☐ Medications
- ☐ Immunizations
- ☐ Other test results (specify) _____
- ☐ Other _____
- ☐ Dates of service _____

This protected health information is being used or disclosed for the following purposes:

- ☐ At the request of myself
- ☐ Other _____

I would like to be contacted at my:

- ☐ Home phone: _____
- ☐ Cell phone: _____
- ☐ Other: _____
- ☐ Work phone: _____
- ☐ Mail

Regarding the office staff or physician leaving information or confirming appointments on my answering machine, voice mail or with my answering service?

- ☐ Yes, I give my permission for medical information to be left on my answering systems.
- ☐ No, I do not want messages or medical information left on my answering systems.

This authorization shall be in force and effect until revoked at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at the above address. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA Rule or state law. I acknowledge that a copy of Dr. Biebel's/Dr. DeCotiis'/Lagnese's Notice of Privacy Practices has been provided to me.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority