PATIENT NAME_____ ACCOUNT #_____

PATIENT INFORMATON RELEASE

_____
PATIENT'S NAME

I give permission to this medical office to discuss my protected (personal) health information with the following people:

_____
PRINT NAME RELATIONSHIP

_____
PRINT NAME RELATIONSHIP

_____
PRINT NAME RELATIONSHIP

_____
PATIENT'S SIGNATURE DATE

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REORDERS: (516) 487-1600

NOTICE OF HIPAA PRIVACY POLICY
ACKNOWLEDGEMENT OF RECEIPT

☐ **Patient / Representative Signature** _____
ACKNOWLEDGEMENT OF RECEIPT

☐ **Patient / Representative Declined To Sign** _____
SIGNATURE OF MEDICAL OFFICE STAFF ACKNOWLEDGING PATIENTS REFUSAL TO SIGN

PRINT NAME_____ **DATE**_____

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