

Baher Yanni M.D. Edward Alexeev M.D. Salah Mohamed M.D. Hossam Mohamed M.D. Amanda Morris PA-C, Alexa Nappi PA-C

Authorization for Release of Information (HIPAA)

Patient Name:	Date Of Birth:
Patient Signature and Date:	
11. Designation of Certain Relatives, Close Friends and Other Caregivers:	
A. I agree that the Practice may disclose certain inform other caregiver since such person is involved with my that case, the Physician Practice will disclose only in involvement with my health care or payment relating to manner.	health care or payment relating to my health care. In aformation that is directly relevant to the person's
Home Telephone / Cell Number:	Written Communication:
Ok to leave message with detailed information	Ok to mail or fax to my home address
Leave message with call back numbers only	Ok to mail or fax to my work/office add
	Ok to Email
B. I designate the following persons listed below as relating to my health care for the purpose of the practi understand that I am not required to list anyone. I als in writing.	ice making the limited disclosures described above. I
Print Name:	Last 4 digits of SS#
Print Name:	Last 4 digits of SS#
Print Name:	Last 4 digits of SS#
C. The following person (s) are not authorized to receive my Patient Health Information:	
Print Name:	Print Name:
Signature and Date of Patient/Parent/ Guardian	
111. The privacy rule generally requires healthcare prorequests for, Patient Health Information to the minimum provisions do not apply to uses or disclosures mad patient/parent/guardian. Healthcare entities must ke Information provided below will constitute an adequat and Health Care Operations may be permitted without	n necessary to accomplish the intended purpose. The e pursuant to an authorization requested by the ep a record of Patient Health Information disclosures. e record. Use and disclosures for Treatment, Payment,
Date of Disclosure Disclosed to whom address/fax	# Description of Disclosure Date of Service