Baher Yanni M.D. Tolga Kapusuz M.D.
Amanda Morris PA-C, Payal Patel PA-C, Carmen Cheng PA-C
Hye Min Kim APN

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 information to a family member, close personnel friend or other caregiver since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner.

Home Telephone / Cell Number: _____

_____ Ok to leave message with detailed information

_____Leave message with call back numbers only

Written Communication:

_____Ok to mail or fax to my home address

_____Ok to mail or fax to my work/office add

_____ Ok to Email

B. I designate the following persons listed below as persons involved with my heath care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

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 providers to take reasonable steps to limit the use of, and requests for, Patient Health Information to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/ guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided below will constitute an adequate record. Use and disclosures for Treatment, Payment, and Health Care Operations may be permitted without prior consent.

Date of Disclosure	Disclosed to whom address/fax #	Description of Disclosure	Date of Service