HIPAA Release of Medical Information

Part I

Patient's Legal Name _____

BY SIGNING BELOW, I understand that under
The Health Insurance Portability & Accountability Act of 1996,
I have certain rights to privacy regarding my Protected Health Information (PHI).
I have been offered, received, read and understand the
Alexandria Otolaryngology Assoc. Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Guardian Date

Part II

I authorize AOA to release my medical information, including prescriptions,
X-rays, orders, doctor excuse, billing information, etc to:
(NOTICE: This is NOT a records release, only information requested.)

If you answer Yes to any of the following, please list a name.

Spouse	◯ Yes	◯ No	_____ Name
Children	◯ Yes	◯ No	_____ Name
In-Laws	◯ Yes	◯ No	_____ Name
Parents	◯ Yes	◯ No	_____ Name
Siblings	◯ Yes	◯ No	_____ Name
Other	◯ Yes	◯ No	_____ Name

Part III

Authorization to leave appointment information with a person or voicemail:

Home	◯ Yes	◯ No	_____ Phone Number
Work	◯ Yes	◯ No	_____ Phone Number
Relative	◯ Yes	◯ No	_____ Phone Number

_____ _____
Signature of Patient or Parent/Guardian Date