NAME: _____

DOB: _____

HIPPA & PRIVACY ACT

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this **authorization** is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ Date of Birth: _____ Social Security # _____

Patient's address: _____

I authorize the release of all my medical record information from the office of Dr. Michael J. Moskal to the following persons for the purpose of the individuals listed below to assist in my care:

_____ _____/_____

(Please List Emergency Contact here) Name Relationship

_____/_____ _____/_____

Name Relationship Name Relationship

Must be completed for all **authorizations.**

The patient or the patient's representative must read and initial the following statements:

1. I understand that this **authorization** will expire on __ __ / __ __/ __ __ __ __ or 2 years following date signed. Initials: _____

2. I understand that I may revoke this **authorization** at any time by notifying the practice in writing, but if I do, it won't have any affect on any actions they took before they received the revocation. Initials: _____

Do you have a **power of attorney**? **YES** or **NO**

Do you have a **living will?** **YES** or **NO**

Please inform the front desk and give them the appropriate documentation. If yes please list Power Of Attorney as a person that we may release information to on one of the four above lines.

_____

Signature of patient or legal guardian Date

(Form MUST be completed before signing)