PATIENT HIPAA MEDICAL RELEASE FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected. This rule provides a standard for health care providers to obtain their patients' consent for uses and disclosures of health information.

We will do all we can to secure and protect the privacy of your personal health records. When it is appropriate and necessary, we will provide requested information – but only to those who are in need of it in order to facilitate and promote your current health care issue resolution.

You may refuse to consent to disclosure of your information. Under the law, we have the right to refuse to treat you if you choose to exorcise this option. You may also request the terminations of information sharing at a later date (completely or in part). Any refusal of consent to disclosure must be done in writing. You may not revoke actions that have already been taken by relying on this or previously signed consent. The full text copy of HIPAA Notice is readily available upon request

All medical records are destroyed after 7 (seven) years of *medical* inactivity.

Your signature authorizes the release of necessary medical information. Your signature also acknowledges the understanding of Friedman Surgical Group, P.C. HIPAA policy as applicable to you and your treatment.

X_____ DATE_____

PATIENT/ RESPONSIBLE PARTY/ GUARDIAN IF MINOR CHILD

MEDICAL INFORMATION RELEASE TO FAMILY/ FRIENDS

NAME **RELATIONSHIP TO YOU**

- _____ _____
- _____ _____
- _____ _____
- _____ _____

Patient Signature **X**_____ DATE _____

Patient Printed Name _____

Revised: May 5, 2017