



Patient Authorization for Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 controls how the Protected Health Information of our patients can be discussed and with whom. This form authorizes me and my staff to discuss your PHI with those you have listed below and in what specific manner.

Individuals to whom your health information may be disclosed (check all that apply)

- Spouse, Name _____
- Parent, Name _____ Parent, Name _____
- Child, Name _____ Child, Name _____
- Other, Name _____

Can a message be left on an answering machine?

- Home Work Cell

What kinds of information can be disclosed?

- All at the doctor's discretion Medical History
- Diagnosis Surgical Information
- Treatment Billing/Insurance Information
- Only return a call message Other _____

The Patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. This authorization will remain in effect unless otherwise revoked by the patient. Release of the PHI covered by this authorization will be disclosed solely for the purpose of keeping designation family members informed of your healthcare condition.

Patient Name: _____

Date of Birth: _____ SS#: _____

Patient Signature/Date _____

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operation

I understand that as part of my health care, Rachel P. Dultz, M.D. Breast Surgical Specialist, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the following rights and privileges:

- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care options

I understand that Rachel P. Dultz, M.D. Breast Surgical Specialist, LLC is not required to agree to restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted in Section 164.506 of the Code of Federal Regulations.

I further understand that Rachel P. Dultz, M.D. Breast Surgical Specialist, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Copy of Federal Regulations. Should Rachel P. Dultz, M.D. Breast Surgical Specialists, LLC change this notice, they will send a copy of any revised notice to the address I have provided (whether U.S. Mail or, if I agree, email).

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.