Patient Consent & Authorization for Release of Protected Health information

Patient Authorization

I, _____, acknowledge and allow PERIODOC, LLC/Dr. Jeffrey Hameroff to share my information with the following people besides those already stated within the Notice of Privacy Practices.

I authorize the release of information including: Treatment records, Billing information, X-rays and digital Imaging, medical conditions, and Photos. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] No information is to be released to anyone

I understand that, per my request , this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payments, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:
_____**PERIODOC, LLC ~ 7320 Forest Oaks Blvd, Spring Hill, FL 34606**_____
The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on December 31, 2017.

The best time to reach me personally is (day)_____ between (time)_____

Please call: [ ] Home _____ [ ] Work _____ [ ] Cell _____

If unable to reach me: [ ] Leave a detailed message OR [ ] E-mail at: _____

Signature:_____Date_____

Name: _____
Please Print
Relationship to Patient: _____

For Office Use Only

Received by: _____Date:_____