Patient's Name:_________________________________ Date of Birth:_______________ EMR# ____________

Disclosure of Health Information

Following the federal guidelines under HIPAA (Health Insurance Portability and Accountability Act) established in 1996, we will not discuss information with anyone other than a person(s) listed below.
This section is intended for listing someone personal to you, such as a spouse, parent, child, relative, or close friend.
This section is not intended for us to contact this person and give them medical information.
Examples of use:

- If we are trying to reach you and the person that answers wants us to give them the information so that they can pass on to you.
- If someone calls into the office on your behalf.
- If someone comes into the office on your behalf.

Any change(s) in this agreement is the responsibility of the patient to notify Bruce E. Freedman, M.D., P.C. This agreement will stay in effect until revoked in writing by the patient.

If you do not wish to list anyone please write **N/A** in this section then sign and date.

At my request, I authorize Bruce E. Freedman, M.D., P.C. to disclose my protected health information to:
(Provide name of person/entity you want to receive your protected health information)

Name:____________________________________ Relationship to Patient: ___________________

Address:____ Phone #: ___________________
Street City State Zip Code

Name:____________________________________ Relationship to Patient: ___________________

Address:____ Phone #: ___________________
Street City State Zip Code

Authorized Signature:____ Date:___________________

Emergency Contact:

Name: ____________________________________ Relationship to Patient: ________________________

Address:____ Phone #: ________________________
Street City State Zip Code

May we leave messages regarding test results and appointments on your answering machine? ☐ Yes ☐ No

I have received a copy of the Private Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Date: __ __ / __ __ / __ __ __ __ Signature: ____