

Internal Medicine Associates of Montgomery Village
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AUTHORIZATION/HIPPA RECORD RELEASE FORM
Use and Disclosure of Protected Health Information (rev 052303)

Patient's Full Name: _____	Date of Birth:	_____/_____/_____
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Person authorized to your medical information: _____
Relationship to Patient : _____
Address & Telephone numbers of person authorized to receive this information:

Please Initial

I understand that if the party receiving this information is not a health care provider or health plan subject to the federal privacy regulations that the information described above may be re-disclosed and no longer protected by the privacy regulations.

Patient initials _____

I understand that I may revoke this authorization, in writing; at any time except to the extent action on this authorization has already occurred upon the effective date. Patient initials _____

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

(Please check all that are appropriate)

DO WE HAVE YOUR PERMISSION TO?

Send a call to remind you of your appointment? Yes _____ no _____

Home _____ Work _____

Leave appointment, billing medical information on your answering machine/voicemail?

Yes _____ No _____

Home _____ Work _____

I give permission to share appointment, billing and/or medical information with the person(s) name :

Patient (or Parent/Legal Guardian) signature	Date
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