Patient's Name: _____ PCC #:_____

Janice H. Loeffler, M.D.P.C
3014 N. Patterson St.
Valdosta, GA 31602
Phone: (229) 242-0194 Fax: (229)242.1785

Authorization for Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996. (HIPAA), your protected health information is confidential unless written authorization is given.

I have reviewed/had access to a copy of the Notice of Privacy Practices of Janice H. Loeffler, M.D.,P.C. on the date indicated below and understand the content. This form will be updated yearly or at any time changes need to be made. This notice was published and became effective September 13, 2013.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the office of Janice H. Loeffler, M.D., P.C.

I also understand that if I wish to receive a copy of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact the Privacy Officer at the office of Janice H. Loeffler, M.D., P.C. at the main phone number.

Therefore, I, _____(print name) hereby authorize Janice H. Loeffler, M.D.P.C., to give my protected health information to the following persons:

NOTE: IF YOU DO NOT LIST YOUR SPOUSE/SIGNIFICANT OTHER ON THIS LIST, WE WILL NOT BE ABLE TO DISCUSS YOUR CARE WITH HIM/HER.

I request that you <u>DO NOT</u> disclose my protected health information to anyone other than me. _____
(*Initials)*

<u>NAME:</u>	**<u>RELATIONSHIP</u>**
_____	_____
_____	_____
_____	_____
_____	_____

_____ Do / _____ DO NOT leave messages on my answering machine or voicemail
_____ Do / _____ DO NOT call me at home. If not, please provide an alternate telephone number _____.
_____ Do / _____ DO NOT call my cell phone Cell (_____) _____ - _____.
_____ Do / _____ DO NOT send me text messages to notify me of appointment reminders.
_____ Do / _____ DO NOT send portal messages.
_____ Do / _____ DO NOT send emails.
_____ Do / _____ DO NOT mail appointment reminders or other correspondence to my home. If not, please provide
Alternate mailing address: _____

This remains in effect from 1 year of date signed.
I also understand that, in an urgent medical situation, Janice H. Loeffler, M.D.P.C may need to contact me by any means available.
_____.
(***Initials)***

_____ _____
Signature of Parent or Guardian Date